Welcome,

Thank you for choosing *Building Bridges Therapy Center*. Prior to your child starting the Special Needs Sibs Are Important Too Group, we will begin with a one-time intake session so that we understand your child's needs as well as strengths. Our goal is to provide excellent care. If you have any questions or concerns regarding your services, please make your therapist aware—they look forward to working closely with you. Additionally, please feel free to contact me anytime, you can reach me at jpagano@bridgestherapy.com or 734-372-1965.

Welcome to Building Bridges!

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

Building Bridges
THERAPY CENTER

REGISTRATION for SPECIAL NEEDS SIBS ARE IMPORTANT TOO GROUP

To get started ALL below information below must be completed and received in our office to schedule your one-time intake session.

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

- **When you have all 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 the information to schedule your one-time intake session.

Building Bridges

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).

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

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

SIBLING 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

MEDICAL HISTORY

Child's Pediatrician or Family Doctor _____

Address_____
Street City State Zip Code

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):_____

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?_____

SCHOOL HISTORY

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

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

_____
_____

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

_____
_____
_____

OTHER

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?

_____

_____

_____

_____

Parent/Guardian Signature:_____

Date: _____

Building Bridges
THERAPY CENTER

MEDICAL INFORMATION

Client's Name: _____ Date of Birth: _____

Child's Name: _____ Child's Diagnosis _____

Address: _____ City_____ State____ Zip Code_____

Home Phone Number: _____ 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 interventions 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.

_____ _____

Client Name (print) Client Signature Date

Building Bridges Therapy Center
Phone: 734-454-0866
Fax: 734-454-1744

Consent to Treatment

Psychotherapy is a technique for treating emotional/ mental distress and some psychiatric disorders. All clinical care will be provided by a qualified and trained professional. Please note that:

- You have the right to refuse any treatments.
- Your agreement to treatment may be cancelled in writing at any time, except to the extent that previous action(s) have been taken that involve a previously provided consent.

Emergencies

In emergencies, please call Common Ground **at 1(800) 231-1127, *Detroit-Wayne County Community Mental Health* at (866) 289-2641, or go to your nearest hospital emergency room.**

As a *mandated reporter*, disclosure of information is required in situations such as those that follow:

- Information needed to process insurance claims, as well as reviews conducted by external auditing bodies.
- If a client is clearly likely to seriously harm him or herself, or seriously harm another person.
- If abuse of a child or senior citizen may have taken place.
- If records are requested by court order or subpoena.

Treatment of Minors: If the client is younger than age 13, both parents have access to the minor client's complete Clinical Record, unless there is a court order prohibiting one of the parents from access.

Your signature on this agreement provides written, advance consent for the above releases of information.

Building Bridges Therapy Center may occasionally consult with other health and mental health professionals about your case. Every possible effort is made to protect client identities. All consultations are noted in the Clinical Record.

___ *(Initial) As a client of Building Bridges Therapy Center, I agree to respect the confidentiality of other clients seeking services at the treatment location*

Your signature below indicates that you have read this agreement and agree to its terms, and also serves as an acknowledgement that you have received the HIPAA Notice of Privacy Practices described above.

X_____
Signature of Client or Responsible Party

___/___/____
Date

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

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 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

NOTICE OF PRIVACY PRACTICES

(Effective April 1, 2003)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU 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 you are 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 care at our Clinic. It also serves as a means of communication among any and all staff involved in your care.

Understanding your health and treatment information rights - Your treatment record is the physical property of the Clinic, but the content is about you 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 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 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 health information to assess the care you 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 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.

_____ _____

Client signature Date

Building Bridges THERAPY CENTER
Phone: 734-454-0866
Fax: 734-454-1744

PATIENT-PROVIDER COMMUNICATIONS

If you consent to the use of email to communicate with you about information related to your case, please complete and sign this Consent below.

(You are not required to authorize the use of email and/or text messaging. A decision not to sign this authorization will not affect your health care in any way. If you prefer not to authorize the use of email we will continue to use U.S. Mail or telephone to communicate with you.)

Print Name _____ Signature _____ Date _____

(Email address to which we may communicate with you) _____

SOCIAL MEDIA PRACTICES

This document outlines the office policies of Building Bridges Therapy Center (BBTC) related to use of Social Media. If you have any questions about anything within this document, we encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when we need to update this policy. If this occurs, you will be notified in writing.

Friending

BBTC and its associates do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and possibly blur the boundaries of the therapeutic relationship.

Interacting

Please do not use messaging on Social Networking sites such as Twitter, Facebook, or LinkedIn to contact associates of BBTC. Engaging in this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Use of Search Engines

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions *may* be made in the event that your safety is of concern.

Building Bridges THERAPY CENTER
Phone: 734-454-0866
Fax: 734-454-1744

Business Review Sites

You may find BBTC or its clinicians listed on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Please know that any listing is NOT a request for a testimonial, rating, or endorsement from you as a client.

If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. Creating a pseudonym that is not linked to your regular email address or friend networks may protect your own privacy and protection.

If you feel that an associate of BBTC has done something harmful or unethical and you do not feel comfortable discussing it with your clinician, you can always contact the Board of Psychology, which oversees licensing, and they will review the services provided.

MI Board of Psychology
611 W. OTTAWA ST.
P.O. BOX 30670
LANSING, MICHIGAN 48909
bhcshelp@michigan.gov

Location-Based Services

If you used location-based and/or check-in services on your mobile phone, you may wish to be aware of the privacy issues related to using these services.

_____ Please provide your initials to indicate that you have read and understand the social media policies used at Building Bridges Therapy Center