Welcome,

Thank you for choosing *Building Bridges Therapy Center*. Here is what to expect as you begin services with us. We begin with an evaluation so that we understand your needs as well as your strengths. Therapy goals and/or recommendations are then created. We utilize a variety of assessments and treatment procedures to provide a customized plan. We believe in collaborating with other professionals both at Building Bridges and elsewhere, because shared knowledge leads to the best therapy. All our therapists are certified or licensed and qualified in their respective fields.

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

REGISTRATION for ADULT: PSYCHOLOGY

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

- **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 therapy session(s).

ADULT CLIENT INFORMATION

Today's Date _____/_____/_____

CLIENT'S INFORMATION

Client Name: ____ Sex:__________

Date of Birth ___/___/___

Address ______________________________ City ________________ State____ Zip ______

Primary Care Provider: ____

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 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: ____________________

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** ____________________

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

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: ____________

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

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.

Recurring *No Shows, late cancellations* and/or *late arrivals and late parent pick-ups* are subject to fees. Parents will be provided with a warning before these fees are incurred.

If there are more than 6 late arrival/pickups or no shows in any 12 month period, this will result in the discontinuation of services. Any potential discontinuation will first be discussed with the parent.

FEES:

- Recurring No Shows, late cancellations and/or late arrivals and late parent pick-ups or chronic cancellations may result in a charge of 50% of the therapy fee.
- If you have an outside source of funding such as an insurance company, these fees will be charged directly to you and not the outside agency.
- We will send an invoice to you once fees have incurred.

NOTICE FOR SPEECH-LANGUAGE THERAPY 30-MINUTE SESSIONS ONLY

For BCBS, BCN, Priority Health, Aetna.
Please be aware that we are unable to bill insurance if you are more than 7 minutes late for a 30-minute speech-language session. If you are more than 7 minutes late we can either bill you directly at our private pay rate of $64.00 or you can choose to not have your child seen that day.

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 to the office or Clinical Director. We appreciate your cooperation in this matter.

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

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.

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

PSYCHOLOGY INFORMATION SHEET

Phone: 734-454-0866
Fax: 734-454-1744

Patient Name:
DOB:
Insured:
Insurance ID:
Referring Dr.:
DX Code:

INDIVIDUAL/ COUPLE/ FAMILY INFORMATION SHEET

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session. Date: ____________________

Your Full Name: ____________________

Address: ____________________

City, State: ____________________ Zip: ____________

Home Phone: (   ) ____________________ May I leave a message? (circle) yes / no

Cell/ Other Phone: (   ) ____________________ May I leave a message? (circle) yes / no

Email: ____________________ May I email you? (circle) yes / no
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): ____________________

Birthdate: ______ / ______ / ______ Age: ______ Gender: ____________

Education: ____________________

Ethnicity: ____________________

Are you currently employed? (circle) yes / no

If yes, what is your current employment situation? ____________________

Employer: ____________________

Position: ____________________ For how long? ____________

Do you enjoy your work? Is there anything stressful about your current work? ____________

____

____

PSYCHOLOGY INFORMATION SHEET

Phone: 734-454-0866
Fax: 734-454-1744

Do you consider yourself to be spiritual or religious? (circle) yes / no

If yes, describe your faith and/or religious or spiritual affiliation: ______________________

Marital/ relationship status:

- ☐ Never married
- ☐ Domestic Partnership
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Other (describe) ________________

Your partner/ spouse/ primary partner's name: ______________________________

How long have you been together? ______________________________________

Address (if different): ____

City, State: ___________________________________ Zip: _________________

Home Phone: (   ) _________________________ May I leave a message? (circle) yes / no

Cell/ Other Phone: (   ) _________________________ May I leave a message? (circle) yes / no

Names and ages of all children in the home: __________________________________

____

Names and ages of all children *not* in the home: ______________________________

____

Who shall I contact in case of emergency?

Name: ________________________________ Phone: (   ) ____________________

Relationship: ______________________________

PSYCHOLOGY INFORMATION SHEET

Phone: 734-454-0866
Fax: 734-454-1744

Medical and Health History
Please complete a medical history for all participants.

Name: ______________________ Date: __________

List any allergies you have: ______________________ None: ________

Primary Care Physician: ______________________

Address: ______________________

City, State: ______________________ Zip: __________

Primary Care Physician's phone number: (   ) ______________________

Date of your most recent physical examination: ______________________

1. Are you currently taking any prescription medication? (circle) yes / no

If yes, please list all current medications and dosages:

Name of Medication	Dosage	Name of Prescribing Doctor	When did you start taking it?

2. How would you rate your current physical health? (please circle)

Poor   Unsatisfactory   Satisfactory   Good   Very good

Please list all current or past health problems, and any major operations:

Current	Past

PSYCHOLOGY INFORMATION SHEET

Phone: 734-454-0866

Fax: 734-454-1744

Present Areas of Concern

All people encounter difficulties from time to time. Please indicate with a check mark those areas of concern which you believe pose particular challenges for you at this time.

TENSIONS/ WORRIES

- ☐ Fearful
- ☐ Panicky
- ☐ Feeling keyed-up or on-edge
- ☐ Easily fatigued
- ☐ Difficulty concentrating
- ☐ Repetitive worries
- ☐ Repetitive actions to prevent stress
- ☐ Fear of dying
- ☐ Irritable
- ☐ Frequent stomachaches
- ☐ Frequent headaches
- ☐ Specific fears (indicate ______________________________)

EMOTIONS

- ☐ Sadness or tearfulness
- ☐ Low self-esteem
- ☐ Lack of enjoyment/ interest
- ☐ Low energy
- ☐ Feelings of worthlessness
- ☐ Feelings of guilt
- ☐ Grieving
- ☐ Feeling hopeless
- ☐ Over-excited
- ☐ Under-excited
- ☐ Angry
- ☐ Slow-moving/ under-active
- ☐ Moody
- ☐ Difficulty controlling temper
- ☐ Thoughts of hurting self
- ☐ Thoughts of doing something uncontrolled

OTHER

- ☐ Career indecision
- ☐ Identity issues
- ☐ Eating problems
- ☐ Weight loss or gain
- ☐ Substance abuse
- ☐ Excessive use of alcohol
- ☐ Unusual thoughts or feelings
- ☐ Legal problems

ATTENTION / LEARNING

- ☐ Memory difficulties
- ☐ Disorganization
- ☐ Difficulty with attention
- ☐ Lose things frequently
- ☐ Easily distracted
- ☐ Forgetful
- ☐ Fidgety
- ☐ Feelings of restlessness
- ☐ Act without thinking
- ☐ Learning disability
- ☐ Difficulty reading
- ☐ Difficulty writing
- ☐ Difficulty understanding what others say

INTERPERSONAL STRESSES

- ☐ Lonely or isolated
- ☐ Difficulty with coworkers
- ☐ Difficulty with boss
- ☐ Difficulty with family
- ☐ Difficulty with friends

REACTIONS/ LIFESTYLE

- ☐ Too emotional
- ☐ Under emotional
- ☐ Like to be the center of attention
- ☐ Hard to trust others
- ☐ Feel people talk about me
- ☐ Avoid people when possible
- ☐ Fear of criticism
- ☐ Difficulty with decisions
- ☐ Fears others will abandon me
- ☐ Difficulty doing things on own
- ☐ Perfectionist
- ☐ Overly focused on work
- ☐ Rigid/ stubborn
- ☐ Fluctuating, unstable relationships
- ☐ Reckless
- ☐ Feelings of emptiness
- ☐ Difficulty following rules
- ☐ Physically aggressive
- ☐ Preoccupied with fantasies of success
- ☐ Special talents
- ☐ Eccentric

PSYCHOLOGY INFORMATION SHEET

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

PSYCHOLOGY INFORMATION SHEET

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.

CONFIDENTIAL: Not to be re-released without express written

Building Bridges

CONFIDENTIAL EXCHANGE/RELEASE OF INFORMATION FORM

CLIENT NAME: ______________________ **DOB:** ______________

Date this form was reviewed/given to parent/guardian: ________

Building Bridges requests parent/guardian permission to exchange information with the provider listed in the right column of this form.

A. BUILDING BRIDGES PROVIDER INFORMATION

Provider Name: ______________________

Address: 46200 Port St., Plymouth, MI 48170

Phone: 734-454-0866 Fax: 734-454-1744

Email: ______________________

MODES OF COMMUNICATION

(Check all modes of communication that you agree to)

☐ **All modes of communication listed**

☐ Phone ☐ Email ☐ Fax

☐ In person ☐ Mail ☐ Drop off/Courier

INFORMATION/DOCUMENTS THAT BUILDING BRIDGES CAN SHARE WITH OTHER PROVIDER:

☐ Diagnostic Evaluation Report(s)

☐ Treatment Assessment Report(s)

☐ Treatment Recommendations

☐ Progress Report(s)

☐ Discharge Summary

☐ Other (specify): ______________________

☐ IFSP/IEP (most current)

☐ CMH Personal Plan

☐ Current Medication List/Regimen

B. OTHER PROVIDER INFORMATION

Agency Name: ______________________

Provider Name: ______________________

Address: ______________________

Phone: __________ Fax: __________

Email: ______________________

MODES OF COMMUNICATION

(Check all modes of communication that you agree to)

☐ **All modes of communication listed**

☐ Phone ☐ Email ☐ Fax

☐ In person ☐ Mail ☐ Drop off/Courier

INFORMATION/DOCUMENTS THAT PROVIDER LISTED ABOVE CAN SHARE WITH BUILDING BRIDGES:

☐ Diagnostic Evaluation Report(s)

☐ Treatment Assessment Report(s)

☐ Treatment Recommendations

☐ Progress Report(s)

☐ Discharge Summary

☐ Other (specify): ______________________

☐ IFSP/IEP (most current)

☐ CMH Personal Plan

☐ Current Medication List/Regimen

OPT OUT

I do not wish, and do not give my permission to have information shared with:

☐ Other provider from above: ______________________

☐ I am not currently receiving services from any other service providers

CONSENT

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the clinician/facility listed in Section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will remain in place for the duration of services or until the consumer states otherwise. I understand that I may revoke my consent at any time except to the extent that action has already been taken in reliance on it.

Parent/Guardian Signature: ______________________ Date: __________

FOR CLIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.