SUMMER

Social Skills Roadmap

Middle/High School

REGISTRATION PACKET

Building Bridges
THERAPY CENTER

SUMMER REGISTRATION FORM

CHILD'S NAME: _____
Last First

BIRTHDATE: _____ AGE: _____ GRADE: _____

PARENTS: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

HOME TELEPHONE: _____ CELL: _____

EMAIL: _____

See our **summer flyer** and print and complete the **summer registration packet** for the group you are enrolling in. These are found on our website: www.bridgestherapy.com, under **What's New at BBTC** and linked as **Summer Registration Packets.** **Register by Monday, May 11th, 2020.**

Skill Builders or Communication FUNdamentals or Social Skills Roadmap

4-week session: Monday, June 22-Thursday, July 16, 2020
3-week session: Monday, July 27-Thursday, August 13, 2020
Discount on the 3-week session when signing up for both sessions

Group Placement Screening: Saturday, May 16, 2020 for Skill Builders, Communication FUNdamentals and Social Skills Roadmap (Six-Week Skill Workshops do not attend).

Skill Builders

Meets 2 days a week for 2 ½ hours each day.
Circle Session and days: 4-week program: 2 days: $770.00
3-week program: 2 days: $570.00
(3-week session discounted to $520 If registering for both groups)

Social Skills Roadmap or Communication FUNdamentals

Circle:
Social Skills Roadmap Elementary (ages 5-9) Meets 9AM-Noon Tues/Weds/Thurs
or
Social Skills Roadmap Middle School/High School: Meets 1-4 PM Tues/Weds/Thurs
Circle Session: 4-week program: $910.00
3-week program: $690.00
(3-week session discounted to $625 If registering for both groups)

Communication FUNdamentals (ages 5-9) Meets 1:15-3:45 PM on Monday and Wednesday
Circle Session: 4-week program: $670.00
3-week program: $490.00
(3-week session discounted to $440 If registering for both groups)

Return summer registration forms by Monday, May 11, 2020:

- **The 4-week session non-refundable payment is due Monday, May 11, 2020.**
- **The 3-week session non-refundable payment is due Wednesday, June 17, 2020.**

Cash, check, Master Card or Visa accepted. No refunds for missed group therapy sessions.

Six Week Skill Workshops

Meet for 7-weeks but only pay for 6 weeks

Circle:

Pencils, Pens & Practice: school age ($375.00) meets Fridays 10-11 AM

You've Got a Friend: Social Skills for Friendship: ($375.00)
Ages 6-8 years Thursdays 6:00-7:00 PM OR 9-12 years Tuesdays 6:15-7:15 PM

Grass Stains and Games: Motor Skills for Outdoor Fun ($375.00)
Ages 5-7 years Mondays 6-7 PM OR ages 8-12 years Thursdays 6:30-7:30 PM

You GOT This! ($265) age 8 years and up, grouped according to need and age/Mondays

Picky Eaters & Problem Feeders: ($375.00) ages 2-5 years Mondays 11-Noon

Return summer registration forms and full non-refundable payment for Six Week Skill Workshops by Monday, May 11, 2020. Six-Week Skill Workshops do not attend the group placement screening.

Cash, check, Master Card or Visa accepted. No refunds for missed group therapy sessions.

ADDITIONAL PROGRAMS

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

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

May be covered by insurance. Private pay options.

Building Bridges Feeding Program

Contact us for more information about fees and which option may be best for your child.
Feeding services may be covered by insurance.

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 pay, contact the office)

	Circle frequency:	
Speech-Language Therapy		
___ 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: contact us for information

Fast ForWord or IM-Home: Intensive Interactive Metronome: Contact us for details.

Return registration forms and payment to:

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

Building Bridges
THERAPY CENTER

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

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

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 AVAILABILITY: 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

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

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

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.

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

Social Skills Roadmap

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 3 to 4 social skills that you want your child to work on this summer:

What therapy services does your child receive?

Please briefly describe your child's skills.

- Social Skills

- Speech and Language Skills

- Fine and Gross Motor Skills

Are there any behavior challenges which impact learning? Yes or No If yes, please describe. What triggers these challenges and what behavior strategies work best for your child?

Does your child have special interests? What motivates him/her to learn and participate?

What else would you like us to know?

Parent Signature: _____

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

Building Bridges
THERAPY CENTER

Middle/High School: Daily Living Skills

Name: _____ Date:_____

During this class the goal is to expose the students to multiple different activities that they engage in daily to help them gain independence with these skills. These include but are not limited to money management-filling out deposit slips, keeping track of money, sorting/folding clothes/towels, making a bed, using simple tools; hammer, screwdriver, keys, staplers etc., Filling out application, safety, kitchen activities- cooking, cleaning, food prep and simple cleaning. We will make these activities fun!! If there are additional ideas you have please let me know and we can incorporate it into class.

Areas of focus you would like to see reviewed in this class:

_____

_____

_____

Activities of Daily Living participates in at home already: i.e. chores, projects etc. _____

_____

_____

Are there any medical concerns:

_____

Any other information you would like to provide: