



## 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](mailto:jpagano@bridgestherapy.com) or 734-372-1965.

Welcome to Building Bridges!

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



## **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](http://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](mailto:office@bridgestherapy.com)
- Our Psychologist will contact you after receiving all the information to schedule your one-time intake session.



**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: \_\_\_\_\_



## 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



**PERTINENT HISTORY QUESTIONNAIRE**

Today's Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone #: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Language Spoken in Home: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_  
Occupation: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Daytime Phone #: \_\_\_\_\_  
Occupation: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Emergency Contact & Phone #: \_\_\_\_\_

Who referred you to Building Bridges Therapy Center?  
\_\_\_\_\_

What is the relationship of the person completing this application to the child?  
Biological Parent: Mother \_\_\_\_\_ Father \_\_\_\_\_  
Adoptive Parent: Mother \_\_\_\_\_ Father \_\_\_\_\_  
Step-Parent: Mother \_\_\_\_\_ Father \_\_\_\_\_  
Foster Parent: Mother \_\_\_\_\_ Father \_\_\_\_\_  
Other: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Other

All persons living in the home:

Name	Age	Relation to patient	Highest Grade Completed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## 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: \_\_\_\_\_



## **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: \_\_\_\_\_

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### **In case of an emergency, please contact:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Alternative Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

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### **Allergies:** yes/no

If yes, please list allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### **Dietary considerations:** yes/no

If yes, please list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### **Medications:** yes/no

If yes, please list medications: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

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### **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





### 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

# 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



## 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:

- ① Oral temperature of 100.5 or higher
- ① Intestinal problems with diarrhea or vomiting
- ① Any type of undiagnosed rash
- ① Any type of communicable illness (chicken pox, measles, impetigo, pink eye, strep throat, etc.)
- ① Congestion or mucous discharge of the eyes, nose or ears
- ① Body aches, headache, and feeling very tired
- ① 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:

- ① Has been free of a fever (100.5 or greater) for at least 24 hours without the use of fever reducing medications.
- ① Has been free of vomiting, diarrhea, rash, eye, ear and nasal drainage for at least 24 hours
- ① Has received antibiotics for strep throat or medicated eye drops for the treatment of pink eye for a minimum of 24 hours
- ① 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:

- ① Wash hands often with soap and water or an alcohol-based hand rub
- ① Cover coughs and sneezes with tissues or use elbow, arm, or sleeve instead of a hand when tissue is not available
- ① Know the signs and symptoms of the flu
- ① Report cases of flu or other communicable illness to Building Bridges staff within 24 hours of the last clinic visit
- ① Be cautious and keep potentially sick individuals at home

X

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

Thank you for your cooperation.



## **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.

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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 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 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.***

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
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.

PSYCHOLOGY INFORMATION SHEET



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  
[bhcshep@michigan.gov](mailto:bhcshep@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