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 both needs as well as 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 whenever appropriate with family and professionals both at Building Bridges and elsewhere, because shared knowledge leads to the best therapy. All of 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!

Janice Pagano MA, CCC-SLP

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

REGISTRATION OVERVIEW FOR SERVICES

To get started, ALL the below information must be completed and received.
You will be contacted to schedule your therapy session.

Documents Required for all Services

- o Completed Welcome Packet (this document)
- o Applicable History & Intake Packet (see separate links on our website)

Additional Documents Required for Insurance Coverage

- o A copy of your insurance card (front and back)
- o A copy of your driver's license (front and back)
- o A Doctor referral/script (Occupational, Physical and Speech Therapy Services Only)

(the following needs to be included):

- Date
- Patient/Client name
- Type of therapy to be received (speech-language, occupational, etc.)
- Evaluation and treatment frequency 1-2x/week
- Diagnosis Code (ICD 10)
- Doctors name, signature and NPI #

Documents Required if Applicable

- o A copy of any Speech-Language Therapy, Occupational Therapy, Physical Therapy and/or Psychological evaluation report received within the last 12 months

---

When you have all of 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

We will contact you within two weeks after receiving *ALL* of the information to schedule your therapy session(s). If for some reason you do not hear from us, please contact us at 734-454-0866 or at office@bridgestherapy.com.

Important Note: Please contact your insurance to verify benefits. An insurance verification form is included in the welcome packet.

Special Note for Emailed Welcome Packets: If sending your welcome packet via email, please complete the section below and sign below:

> *I have elected to electronically complete and/or submit the Welcome Packet and/or any other new client documents. I understand that my email platform may not be HIPAA secure, and I consent to using email to send this information and to receive related communications from Building Bridges Therapy Center. I understand that if I elect to complete these documents electronically, my typed name in any "signature" fields represents my signature and carries the same acknowledgment and consent as does my physical signature.*

_____

Client Name

_____

Parent/Guardian's Name (if applicable)

_____

Client or Guardian Signature Date

CLIENT INFORMATION

Today's Date _____/_____/_____

What Service(s) are you requesting? ☐ Speech ☐OT ☐PT ☐Music ☐Psych

CLIENT INFORMATION

Client Name: _____

Sex: _____

Date of Birth: ____/____/____

Address:

_____ City: _____

State: _____ Zip: _____

if applicable: Home#: _____ Cell#: _____

Work#: _____ Email: _____

Physician

Name: _____ Phone#: _____

Fax#:_____

PARENT/GUARDIAN INFORMATION (ONLY REQUIRED IF CLIENT IS A MINOR)

Parent/Guardian #1:

Name: _____ Sex:_____

Address (if different from above):

_____

Home#: _____ Cell#: _____

Work#: _____ Email: _____

Parent/Guardian #2:

Name: _____ Sex:_____

Address (if different from above):

_____

Home#: _____ Cell#: _____

Work#: _____ Email: _____

Social Security#: _____ Name: _____
Social security # is required for the adult financially responsible for payment of services.

Whom can we thank for referring you to Building Bridges?
- ◯ Dr: _____
- ◯ Friend: _____

No referral; we found Building Bridges through…
- ◯ Social Media
- ◯ Internet Search
- ◯ Other: _____

INSURED'S INFORMATION

If billing insurance, please complete:

Primary Insured's Name: _____ Sex: _____

Primary Insurance Company: _____

Policy #: _____

Group#: _____

Insurance Phone # (On back of Insurance Card):

_____

Secondary Insured's Name: _____ Sex: _____

Secondary Insurance Company: _____

Policy #: _____

Group#: _____

Insurance Phone # (On back of Insurance Card):

_____

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.

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, insurance or agency fails to provide the payment for services for any reason, the client is solely and individually responsible for all fees for services provided.
3. Invoices are to be paid in full when billed. 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. Payment can be made by cash, check or credit card. Cash and Check payments can be made directly at the front office, mailed, or put in the locked payment drop box outside the front office. Credit card payments (Mastercard or Visa) can be made over the phone, directly at the front office or on our website (www.bridgestherapy.com).
5. 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. This fee may not apply in situations of an emergency or illness. If a client is late for a therapy session, the client is responsible for the fee for the entire scheduled session.
6. Prior to the last scheduled day of services, accounts must be paid in full or an alternate payment plan must be established. If billing insurance, your final balance may not be available at that time and payment in full will be required as soon as you receive your final invoicing.
7. In situations of divorce, separation, or other situations of shared custody, the adult who signs this policy shall be responsible in full for payment.
8. In order to service client accounts or to collect any amounts that are due, Building Bridges Therapy Center and debt collection service providers may contact clients at any telephone number or email address associated with their account.
9. The terms of this payment policy apply for all services currently being provided to as well as any future services provided by Building Bridges Therapy Center.
10. 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, are costly. If the financial considerations are prohibitive, please speak with our biller, Ashlee Mucha, 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 in full on a monthly schedule, or according to any established payment plan that may be applicable.

_____

Client Name

_____

Parent/Guardian's Name (if applicable)

_____

Client or Guardian Signature Date

ATTENDANCE POLICY

Our office should be notified 24 hours in advance when a client cannot keep a 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. Clients will be provided with a warning before these fees are incurred.

More than 8 late arrival/pickups or no shows in any 12-month period will result in the discontinuation of services. Any potential discontinuation will first be discussed with the client.

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 or you can choose to not have your session that day.

Our staff is dedicated to work diligently to help each client 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.

I have read this policy and agree to the stated terms.

_____

Client Name

_____

Client or Guardian Signature Date

HEALTH POLICY

Staff, clients, and guests should not come to the clinic or the waiting room when the following conditions are present. Anyone presenting with these symptoms will be asked to leave the clinic or waiting room.

1. Oral temperature of 100.4˚F or higher
2. Intestinal problems with diarrhea or vomiting
3. Any type of undiagnosed rash
4. Any type of communicable illness (chicken pox, measles, impetigo, pink eye, strep throat, etc.)
5. Congestion or mucous discharge of the eyes, nose, or ears
6. Body aches, headache, and fatigue
7. Persistent cough, sore throat, or shortness of breath

A sick individual should not return to the clinic until he or she has met all of the following:

8. Has been free of a fever (100.4˚F or greater) for at least 24 hours without the use of fever-reducing medications
9. Has been free of vomiting, diarrhea*, rash, eye, ear, and nasal drainage for at least 72 hours
10. Has received antibiotics for strep throat or medicated eye drops for the treatment of pink-eye for a minimum of 24 hours
11. In the case of chicken pox, has waited at least 1 week after the eruption of first crop of lesions *and* has had all lesions become crusted

We encourage staff and families to:

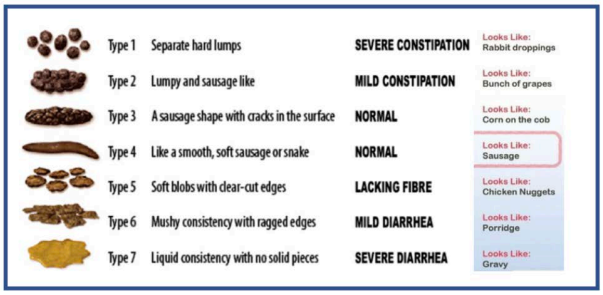
12. Wash their hands often with soap and water or an alcohol-based hand rub
13. Cover their coughs and sneezes with tissues or use the elbow, arm, or sleeve instead of a hand when tissue is not available
14. Know the signs and symptoms of the flu
15. Report cases of flu or other communicable illness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

~~ Thank you for your cooperation ~~

I have read this policy and agree to the stated terms.

_____
Client Name

_____
Client or Guardian Signature Date



** Diarrhea Information. Building Bridges Therapy follows the standard definition of diarrhea as defined as three loose stools in a 24-hour period. The Bristol Stool will be used in determining diarrhea for stool meeting criteria of levels 6 or 7.*

GENERAL MEDICAL INFORMATION

Client Name: _____ Date of Birth: _____

Parent/Guardian Names (if client is minor): _____

In case of an emergency, please contact:

Name: _____ Phone Number: _____

Alternative Phone Number(s): _____

Relationship to client: _____

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, EpiPen or seizure medication:

_____

_____

If client is a minor: In an emergency, I authorize Building Bridges Therapy Center to obtain emergency medical treatment, if the parent is not immediately accessible.

_____

Client Name

_____

Parent/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

(Version April 1, 2020)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT THE CLIENT (YOU OR YOUR CHILD) MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN BELOW.

Understanding your treatment record - A record is made each time a client 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 care at our Clinic. It also serves as a means of communication among any and all staff involved in the treatment of the client.

Understanding your health and treatment information rights - The client treatment record is the physical property of the Clinic, but the content is about the client 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 the client. 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.

Client'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 the client'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 the client'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 the client's, 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 the client's health information to assess the care received and the outcome of treatment. 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 policy for specific disclosure*s – It is our policy to not disclose any of the client'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.

_____

Client Name

_____

Client or Guardian Signature Date

CONSENT TO TREATMENT

Please carefully read and initial each section, and sign at the end of this document to indicated your consent.

Occupational Therapy, Physical Therapy, Speech Language Therapy, and Music Therapy

Occupational Therapy, Physical Therapy, Speech Language Therapy, and Music Therapy are modalities for treating development and function delays, dysfunctions and disorders. All services 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.

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 or neglect of a child or senior citizen may have taken place.
- If records are requested by court order or subpoena.

→_____ I understand, agree with, and consent to this section

Initial

Psychotherapy, Counseling

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.

For 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 or neglect of a child or senior citizen may have taken place.
- If records are requested by court order or subpoena.

Your signature on this document provides written, advanced consent for the above release of information.

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.

Special Contact for Psychotherapy, Counseling or Psychological Testing
If you would like to be contacted only at a specific phone number, please provide:
_____

If this is left blank, your therapist for these services will use the any of the telephone numbers you have provided.

If you do *not* want me to leave a message via text or voicemail, please tell me how you want me to reach you by phone: _____

Outside Consultation
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.

→_____ I understand, agree with, and consent to this section
Initial

Social Media Practices

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.

→_____ I understand, agree with, and consent to this section

Initial

Electronic Communications

Initial this section to indicate consent to the use of email and/or text to communicate with you about information related to your case.

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

→_____ I understand, agree with, and consent to this section

Initial

Non-Covered Services Consent

Clients may request non-covered and/or non-authorized services that are payable by the client (or client's family). By initialing below, I acknowledge that I am aware that

such non-covered and/or non-authorized service may be provided and that my insurance company will not be responsible for the fee for such services.

→_____ I understand, agree with, and consent to this section

Initial

Telehealth Services

Following is 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 Therapists, 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 HIPAA 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 as described in this document.

By initialing this section:

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 understand, agree with, and consent to this section

Initial

Other Clients

As a client of Building Bridges Therapy Center, I agree to respect the confidentiality of other clients seeking services at the treatment location.

→_____ I understand, agree with, and consent to this section

Initial

I hereby acknowledge that I have read and fully understand all sections of this document and give consent for Building Bridges Therapy Center to provide me with evaluation and/or treatment.

_____

Client Name

_____

Client or Guardian Signature Date

CLIENT SCHEDULE AVAILABILITY

Client's Name: _____

Please select the therapy service(s) you are requesting:

☐ **Speech Therapy** ☐ **Occupational Therapy**

☐ **Physical Therapy** ☐ **Music Therapy**

☐ **Counseling**

Availability:
My child is available for therapy at the following days/times:
(Mark your availability with an "X")
(Any blocks left blank means you are unavailable)

Day	Mon	Tues	Wed	Thurs	Fri	Sat
8 am – 12 pm						
12 pm – 4 pm						***Not available***
After 4 pm					***Not available***	***Not available***

If your child will be receiving more than one therapy service, do you prefer to have therapy back to back? ☐ Yes ☐ No

If yes, we will try our best to accommodate.

INSURANCE VERIFICATION

We urge you to call and verify your benefits before beginning therapy. It is extremely important to understand your deductible amount, out of pocket maximum cost, co-pay/co-insurance and visit limitations as you are responsible for any charges not paid by your insurance.

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: _____

If applicable, is Autism a benefit covered under your insurance plan? ☐ YES ☐ NO ☐ N/A

If yes, do visit limitations apply? ☐ YES ☐ NO

Visit Limitations per year (complete applicable information):

Primary Insurance: _____Speech _____OT _____PT ____Psych

Speech, OT, or PT:

Are I visit limitations combined per year? ☐ YES ☐ NO

Max visits per year allowed:_____

Do 2 or more therapy sessions in one day count as 1 visit? ☐ YES ☐ NO

Psych:

Max visits per year allowed: _____

Secondary Insurance: _____Speech _____OT _____PT ____Psych

Speech, OT, or PT:

Are I visit limitations combined per year? ☐ YES ☐ NO

Max visits per year allowed:_____

Do 2 or more therapy sessions in one day count as 1 visit? ☐ YES ☐ NO

Psych:

Max visits per year allowed: _____

Is an authorization required for Evaluation/Assessment?

_____Speech _____OT _____PT ____Psych

Is an authorization required for Therapy?

_____Speech _____OT _____PT ____Psych

Has your child had an evaluation this year?
_____Speech _____OT _____PT ____Psych

If yes, Insurance may not pay for a 2nd evaluation in a year. Please include evaluation report with your welcome packet.

_____
Insured's Name (print)

_____
Insured's Signature Date

_____
Client Name

THERAPY VISIT TRACKING

As you are aware, your insurance plan may only allow a certain number of visits per year (visit limitations). This includes therapy services at Building Bridges Therapy Center as well as any other facility. Please keep track of your visits, **this is your responsibility**.

- Once you have reached your visit limitation for your plan year, please notify us.
- You may then continue therapy at our private pay rate or discontinue therapy until new plan year.

_____
Initial

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

COVID-19 Consent for Face-to-Face Services

Building Bridges Therapy Center follows a plan to safely provide in-person services during the COVID-19 pandemic. This plan is based on input from the State of Michigan and the Center for Disease Control (CDC).

These services will be provided by:

- Following all recommended safety practices (e.g., social distancing, personal protective equipment or PPE)
- Strict adherence to our health policy for both staff and clients/families
- Required health screening for all staff, clients, and families prior to sessions

However, it is impossible to guarantee full safety at all times. As has always been the case, participation in face-to-face services may include exposure to communicable diseases. If your child or a family member has co-existing health conditions or other concerns related to accessing face to face services, please consult with your physician.

Should you choose to wait to resume face-to-face services after the deadline provided by ABA or another therapy service, you may lose your therapy spot, but you will be placed on a preferred waitlist.

I fully understand the above information and give my consent and permission for my dependent to receive face-to-face therapy services.

_____

Client Name

_____

Client or Guardian Date

5/12/2020

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. I understand I will be sent an invoice before the amount due is charged to my card. 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 unpaid services will be charged and these may include unpaid services from prior months.

THIS AGREEMENT REMAINS IN EFFECT UNTIL CANCELED BY THE APPLICANT WITH WRITTEN NOTICE. This agreement may be canceled by the applicant by providing BBTC a written notice at least 30 days in advance of the cancellation date.

_____

Applicant's Name (print)

_____

Applicants Signature Date

_____

Client Name

Building Bridges THERAPY CENTER

OPTIONAL

CONFIDENTIAL EXCHANGE/RELEASE OF INFORMATION FORM

CLIENT NAME: _____ **DOB:**_____

Date this form was given to client or 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	**B. OTHER PROVIDER INFORMATION**
Provider Name: _____ Address: 46200 Port St., Plymouth, MI 48170 Phone: 734-454-0866 Fax: 734-454-1744 Email: _____	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	**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 PROVIDERS: ☐ Diagnostic Evaluation Report(s) ☐IFSP/IEP (most current) ☐Treatment Assessment Report(s) ☐CMH Personal Plan ☐Treatment Recommendations ☐Current Medication List/Regimen: _____ ☐Progress Report(s) ☐Discharge Summary ☐Other (specify): _____ _____ _____ _____	**INFORMATION/DOCUMENTS THAT BUILDING BRIDGES CAN SHARE WITH OTHER PROVIDERS:** ☐ Diagnostic Evaluation Report(s) ☐IFSP/IEP (most current) ☐Treatment Assessment Report(s) ☐CMH Personal Plan ☐Treatment Recommendations ☐Current Medication List/Regimen: _____ ☐Progress Report(s) ☐Discharge Summary ☐Other (specify): _____ _____ _____ _____

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.

_____

Client Name

_____

Client or 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.

OPTIONAL

NON-GUARDIAN AUTHORIZATIONS

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.

_____

Client Name

_____

Client or Guardian Signature Date