



## WELCOME...

Thank you for choosing *Building Bridges Therapy Center*. Established in 1988, Building Bridges has a team of experienced professionals who specialize in working with children. All of our therapists are certified or licensed and highly qualified in their respective fields. We are glad you have selected us, and we are committed to providing you and your family the best possible care.

As a parent, you know more about your child than anyone else. We recognize that your child's care and development involves the whole family, and we will work with you to establish the best individualized treatment program for your child. If you have any questions or concerns regarding your therapy, please make your therapist aware—they look forward to working closely with you. Also, our Lead Clinician, Janice Pagano, is available to help answer questions and address any concerns you may have. Janice has over 25 years of experience with a wide variety of children, and is a great resource for parents (you can reach Janice at our main office number, 734-454-0866). Additionally, please always feel free to contact me to discuss your child's treatment or your services.

Again, we welcome you to our clinic.

Sincerely,

**Laurie Lundblad**

Laurie A. Lundblad, Psy.D., PNP-BC  
Clinical Director



**WELCOME TO OUR OFFICE**

Name of Client: \_\_\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_  
Last First MI  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

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Father's Name: \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_  
Home Phone # (if different from above) \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (only used if account becomes delinquent)  
 I am not providing SS#. (payment due at each session)  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone # \_\_\_\_\_

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Mother's Name: \_\_\_\_\_  
Address (if different from above) \_\_\_\_\_  
Home Phone # (if different from above) \_\_\_\_\_  
Cell Phone # \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (only used if account becomes delinquent)  
 I am not providing SS#. (payment due at each session)  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone # \_\_\_\_\_

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Responsible Party Name: (person paying for services) \_\_\_\_\_  
If different from above:  
Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (only used if account becomes delinquent)  
 I am not providing SS#. (payment due at each session)  
Employer \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Employer Phone # \_\_\_\_\_

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Whom may we thank for referring you to our office \_\_\_\_\_  
Name  
Address  
Or, How did you learn about our office? \_\_\_\_\_

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## **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. We do not bill insurance companies for services, and we are not a network provider with any insurance company. However, clients are sometimes able to receive benefits from their health insurance provider. It is up to the client to determine if therapy is a covered benefit under his or her particular plan. We will gladly assist by providing insurance forms and helping with the necessary diagnostic and procedure codes. 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. If social security numbers are NOT included on the Welcome to Our Office form, payment is due at each session. Your social security number is only used if account becomes extremely delinquent.
4. All initial evaluations and all psychological services are to be paid on the date of service.
5. Payment can be made by cash or check and should be given to the Office Manager or left in the locked payment drop box through the window in the Office Manager's 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. 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.
10. The terms of this payment policy apply for all services currently being provided to as well as any future services provided by our clinic.
11. 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 Brad Naberhaus 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 \_\_\_\_\_



## **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. Failure to notify the office may result in a charge of 50% of the therapy fee. This fee goes directly to the therapist to compensate him or her for time spent planning for your child's session. If your child is late for a therapy session, you are responsible for the fee for the entire scheduled session. If you have an outside source of funding such as an insurance company or a community agency, the cancellation fees and/or fees for the portion of the session missed due to lateness will be charged directly to you and not the outside agency.

Most importantly, consistency of treatment is essential to your child's progress. If we sense that a child does not have consistent attendance in his or her treatment program, we will offer that time slot to someone on our waiting list. Any potential dismissals will be discussed with the parent prior to reaching a decision to terminate therapy.

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 with me directly. 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 99°F 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 (99°F, 37.8°C 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 their hands often with soap and water or an alcohol-based hand rub
- Cover their coughs and sneezes with tissues or use the elbow, arm, or sleeve instead of a hand when tissue is not available
- Know the signs and symptoms of the flu
- Report to the Building Bridges Staff if they come down with the flu or other communicable disease within 24 hours of their last clinic visit
- Err on the side of caution in keeping potentially sick individuals home

**X** \_\_\_\_\_ I have read this letter and agree to the terms stated above.



**RELEASE OF INFORMATION**

I, \_\_\_\_\_, authorize the release of information  
parent's name

regarding \_\_\_\_\_, from Building Bridges Therapy  
Center  
child's name

to the following parties for the purposes of therapeutic and educational planning.  
Information may include evaluation reports, progress notes, and conversations with the  
parties listed below. I understand that copies of reports will be automatically sent as  
indicated below.

Name	Address & Phone #	Send copies of all reports (Y/N)

Signed \_\_\_\_\_

Dated \_\_\_\_\_



## **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



## Waiting Room Guidelines

Building Bridges Parents/Caregivers:

We hope you enjoy our waiting room. We try very hard to provide a space that adults and children can enjoy. We ask that parents/caregivers please:

- Help children keep play volume low. Loud play disrupts therapy and other clients in the waiting room. It also leads to escalating volume of other children's play.
- Direct children to calm, controlled play activities. Reading book with your children is a great activity for the waiting room—we will rotate the books on our bookshelf.
- Instruct children that climbing, running, and standing on furniture is not acceptable play.
- Help your child clean up toys, and please follow the "Playroom Rules."
- Please keep clinic toys confined to the Playroom area.
- Be aware that we have a changing station in our bathroom. This is the only place in our office where diapers should be changed. If you do change a diaper, please notify a staff member and we will take the garbage out.
- Do not leave partially filled coffee cups on shelves or the floor.
- Please help keep the doors to the therapy areas closed. We will also strive to keep these doors closed.

We understand that children like to play—that is what they do best. If the play volume has gotten too loud or the activities too rough, our staff may respectfully direct children and/or ask for your assistance. Please understand that this is being done to ensure a safe and pleasant environment for everyone, and do what you can to help.

Thank you for your cooperation. Following these standards will ensure that the waiting room is a clean, safe space that can be enjoyed by children and adults.



**PERTINENT HISTORY QUESTIONNAIRE**

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

Address: \_\_\_\_\_

Street City State Zip Code

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

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

Occupation: \_\_\_\_\_

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

Occupation: \_\_\_\_\_

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

How did you hear about 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: \_\_\_\_\_

All persons living in the home:

Name Age Relation to patient Highest Grade Completed

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PARENTAL CONCERNS**

Please describe the major concerns you have in seeking help for your child.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How can this facility help you most with these concerns?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL HISTORY**

Child's Pediatrician or Family Doctor \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Code

Please list any other doctors or clinics that have examined this child:

Table with 3 columns: Name, Address, Purpose of Examination. Includes three blank rows for data entry.

**PREGNANCY**

While pregnant did child's mother have any of the following:

Table with 2 columns of conditions and 2 columns of Yes/No responses. Conditions include German Measles, Anemia, Diabetes, High fever, Smoke cigarettes, Emotional Problems, Vaginal infection, High blood pressure, Kidney problems, Drink alcohol.

Were any medications taken during pregnancy? (include vitamins and iron)

\_\_\_\_\_

Has child's mother ever had a miscarriage? Yes \_\_\_\_\_ No \_\_\_\_\_

**BIRTH**

Was the child born early? \_\_\_\_\_ Late? \_\_\_\_\_ or on time? \_\_\_\_\_

Was child born by C-section? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please give reason for C-section \_\_\_\_\_

Approximately how long was mother in labor? \_\_\_\_\_

What was baby's birth weight? \_\_\_\_\_ length? \_\_\_\_\_ Apgar Score? \_\_\_\_\_

What was baby's condition at birth? \_\_\_\_\_

Has child ever had the following:

Table with 2 columns of conditions and 2 columns of Yes/No responses. Conditions include Eye or vision problems, Ear or hearing problems, Allergies, Asthma, Convulsions, Anemia, Vomiting spells, Frequent diarrhea, Meningitis, Head Injury.

Has child had any other health problems not listed above? (describe)

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

Does child take medication on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list medication taken and amount:

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Has the child ever been hospitalized? Yes \_\_\_\_\_ No \_\_\_\_\_

	<u>Hospital</u>	<u>Year</u>	<u>Reason</u>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

### DEVELOPMENT AND SCHOOL HISTORY

At what age did child first:

Sit Alone	_____	Feed self finger foods	_____
Crawl	_____	Speak first real words	_____
Stand Alone	_____	Speak first real sentences	_____
Walk	_____	Become toilet trained	_____

Is child currently enrolled in a school program? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please answer the following:

Name of School: \_\_\_\_\_

Address: \_\_\_\_\_

Grade: \_\_\_\_\_

Has child ever been evaluated by a school diagnostic team? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when was evaluation completed and what were the results?

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Please describe the child's performance at school? What subjects does he/she do well in? What subjects are more difficult?

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

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**SOCIAL – EMOTIONAL DEVELOPMENT**

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

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What methods are used to discipline child?

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Are these methods effective? Yes \_\_\_\_\_ No \_\_\_\_\_

What does your child like to do to occupy his/her time?

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Does child have regular playmates or friends? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there anything else you would like for us to know about your child that was not covered above?

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Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_