Two Locations to Serve You!

Washtenaw County
12319 Highland Road
Suite 501
Hartland, MI 48353
810-991-1211

Livingston County
6276 Jackson Road
Suite K
Ann Arbor, MI 48103
734-821-6915

Welcome to Children's Center for Growth and Development!

We appreciate that you have chosen our center to provide you and your child with the services you need. We look forward to developing a relationship with you and supporting you in this journey! This packet will provide you with the necessary information, policies and permissions to begin therapy. Please use the checklist below to ensure all necessary forms have been completed and reviewed.

This packet includes the following:

- Demographic/Contact Information
- General/School Information
- Parent Concerns/Developmental History
- Policies: Attendance, Finance, General Policies and Procedures (attached for your record)
- Food Permission, Video and Picture Release
- Consent to Release Information
- Policies: Attendance, Finance, General Policies and Procedures (for your record)
- HIPAA: Notice if Privacy and Practices/HIPAA Statement

We encourage parental involvement in our therapy sessions! Initially you are asked to sit off to the side to optimize the effectiveness of the session. Your therapist will indicate to you their desire and the best time for you to become more involved in their session when they feel the time is appropriate. This will help your clinician to focus on your child, their performance and level of assistance needed and not be distracted by conversation or questions.

Siblings are welcome at the center and toys, books and various activities are provided in the waiting area for their use. The supervision and safety of siblings are the responsibility of the parent/caregiver.

We look forward to working with you and your child! Thank you for choosing Children's Center for Growth and Development!

Demographic Information	
Child's Legal Name: Preferred Name:	
DOB:	
Home Address:	
Home Phone Number: Mother's Cell Phone: Father's Cell Phone:	
Primary email address: Would you like to be included in our monthly newsletter? YES NO *Email information is kept confidential and not shared with outside sources! We respect your privacy!*	
Pediatrician: Office Name/Address:	
Emergency Contact: In case of an emergency and you are not available. Name: Relationship: Phone number:	
Does child live with both parents? YES NO If no, please complete the following:	
Mother:	Father:
Address:	Address:
Legal Guardian?	Legal Guardian?
Documentation will be sent to both parents with guardianship in cases of divorce or separation at the address(es) indicated above.	
Our currrent system allows us to securely send text messages for updates such as appointment reminders, rescheduled appointments, closures, etc. All phone numbers are kept confidential and you may unsubscribe from text messaging at any time. ***Are you interested in receiving text messages? YES NO*** If yes, please complete the following:	
Cell Phone number to receive txt msgs:	
Cell phone carrier:	
I understand that I am responsible for any charges I may incur through my cell phone carrier regarding the use of these services. CCGD is not responsible for data/cellular use charges and does *not* charge for the use of these services. **Signature:**	

School/Academic Information	
Name of School:	Current Grade:
History of Early On Services? YES NO If yes, please describe:	
Current Teacher:	
Does your child have a current IEP? YES NO *A copy of the current year IEP is helpful in collaborating with your child's academic team. If possible, please bring a copy of the document and we will be happy to make a copy for our records.*	
Please describe any academic concerns:	
Parent Concerns/Developmental History	
Delivery: vaginal c-section	Full term? YES NO If no, please indicate gestational age:
NICU? YES NO If yes, please describe:	
Feeding Difficulties? YES NO If yes, please describe:	
Please list/describe and medical procedures or diagnoses your child has received:	
Please describe your concerns and reason for this visit: Approximate date your primary concern was observed/diagnosed:	
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Policies and Procedures	
By initialing in the boxes below to the left you agree to the following statements	
	I have received an updated copy of CCGD's HIPAA Privacy statement
	I have received and read CCGD's updated attendance policy and agree to terms and conditions.
	I have received and read CCGD's updated financial policies and procedures and agree to terms and conditions.
	I have received and read CCGD's General Policies and procedures and agree to terms and conditions
Video Release *You may revoke consent at any time in writing*	
	I give permission for my child's picture/video to be used by CCGD for the purposes of training professionals through presentations.
	I give permission for my child's picture/video to be used by CCGD for marketing/publicity (any use of photos/videos for marketing will NOT use your child's name)
	I do not wish for my child's picture/video to be used for purposes other than training his/her specific treatment team
Food Permission/Dietary Restrictions	
Please list any allergens/food sensitivities:	
	My child may participate in food/snacks and does NOT have any dietary restrictions.
	My child may participate in food/snacks if the following dietary conditions are met: List food exclusions here:
	My child may participate in food/snacks however I agree to provide food items.
	My child should NOT participate in food/snacks.

I/we, consent that my minor child _____ may be treated by his/her therapist at Children's Center for Growth and Development, L.L.C.

_____ _____

Legal Guardian Signature: Date

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Consent to Release/Receive Medical Information	
We understand the importance of coordinating and communication with other professionals involved in our child's care. I/We agree to let CCGD share and receive information from other agencies about my child. The following are included in this release:	
Child's Name:	**Date of Birth:**
Name	**Address/Phone Number**
Primary Care Physician:	
School/Academic Personnel:	
Other:	

Authorization to Disclose Medical Information for Insurance and Medical Purposes:
Unless notified by the child's guardian, it is the policy and requirement as a participating provider for CCGD to release any requested medical information to your insurance company. CCGD will send results of evaluations, recommendations, progress reports and discharge summaries to the referring physician as required under CMS guidelines.

_____ _____

Legal Guardian Signature: Date

Attendance Policy

It is very important that therapy sessions are attended regularly as agreed upon between you and your child's therapist. The consistency of attending therapy sessions assures that your child will obtain maximum treatment benefit and assist in reaching the established goals in your child's Plan of Care. We understand that there are times when families need to cancel therapy appointments. In order to allow us to meet the needs of all the children seen at CCGD we have established an attendance policy in order to keep our center running efficiently.

Cancellations:

- I agree to cancel my appointment at least 24 hours in advance for planned absences
- In case of an emergency or illness I will contact the office as soon as possible.
- Regularly scheduled appointments will be reserved for 2 weeks for advance notice of vacation/extended leave of absences
- I understand that attendance is reported in progress reports to referring physicians and a consideration by insurance companies when deciding continued coverage of services

Attendance:

- I commit to attending 75% of all scheduled appointments each month at a minimum
    - 1 scheduled session per week = 3/4 attended sessions per month
    - 2 scheduled sessions per week = 6/8 attended sessions per month
    - 3 scheduled sessions per week = 9/12 attended sessions per month
- If I am able to reschedule any missed appointments within the same month, the cancellation is not considered an absence and no charges will be applied.
- 2 consecutive months of less than 75% attendance may result in discharge of services.
- 3 consecutive months of irregularly attended appointments will be assessed on an individual basis for continued regularly scheduled appointments.

Charges:

- No show/ no call appointments are automatically charged $35.
- Cancellations beyond 75% of scheduled monthly appointments will be charged the following at the end of each month:
    - 1 session per visit = $25
    - 2 or more sessions per visit = $40
    - Multiple family members attending therapy = $40 max
- Charges related to this attendance policy are subject to financial policies and procedures for nonpayment.

CCGD reserves the right to discharge any patient from therapy due to attendance issues.

In the case of a therapist's illness CCGD will make every attempt to provide a substitute for your child's therapy sessions. If a substitute is not able to be provided you will be informed ahead of time regarding the need to cancel. This type of cancellation does *not* apply to the attendance policy and related charges.

_____ _____

Legal Guardian Signature: Date

Financial Policies/Procedures

You certify that you have provided CCGD with the most accurate insurance information available. In addition, you understand that you are financially responsible for all charges not paid by insurance for any reason.
Insurance: CCGD will in good faith make very attempt to seure benefit information from your insurance company prior to your initial visit, however does not guarantee coverage or payment. You are responsible for understanding your insurance benefits, copays and deductibles. The patient's insurance benefit is a contract between the patient and teh insurance carrier; CCGD is not a party to that contract. Any failure to provide CCGD with updated insurance information will result in your being responsible for any balance for services received. CCGD will file claims with participating insurance carriers on your behalf. Some, if not all services a patient receives at CCGD may be a non-covered benefit or not considered reasonable or necessary by insurers. Patients may be billed for such services if applicable.

Co-payments and Deductibles: All copayments and deductibles must be paid at the time of the service provided or as otherwise agreed upon between CCGD and responsible parties. Collection of these fees are paeto the patient's contract with their insurance company. CCGD is required by law to collect such payments.

Method of Payments: CCGD accepts cash, check, VISA, Mastercard, Discover, American Express and all Flex Spending or HSA cards associated with one of these major credit cards.

Patient Statements: Balance statements will be distributed on the 1st of every months and is due and payable when the statement is issued. Balance statements are considered past due if not paid within 30 days of issuance.

Nonpayment: If the patient's account is past due 90 days or greater and the balance has not been paid in full or a payment arrangement made, the bill could be send to collections under the responsible party's name. Until these balances are paid in full, therapy services may be terminated due to non-payment.

_____ _____

Legal Guardian Signature: Date

General Policies/Procedures

Drop Off Policy

Parent/guardians may leave the premises of CCGD during their child's treatment sessions if we have a current cell phone number at sign in. If you do not have a cell phone or means to contact you we require you to remain on the premises.

Parents are expected to be on time for arrive and pick up of their children for appointments a minimum of 10 minutes PRIOR to the end of your child's therapy session so your therapist may provide a summary of the session. If you are late to pick up your child, the staff may not be available to address your home program or questions.

Sick Policy

In order to maintain the heal of staff and other children, please do not bring your child if they have had a fever or experienced symptoms that are contagious within a 24 hour period. If your child shows visible signs of illness their appointment may be rescheduled at the therapist's discretion.

_____ _____

Legal Guardian Signature: Date