Fundamental Therapies

Phone: (248) 606-0551
Fax: (248) 928-5051
www.fundamentaltherapies.com
1950 E Wattles Rd, Suite 108, Troy, MI 48085

Welcome!!

Thank you for choosing Fundamental Therapies! Here is what to expect as you begin services with us:

Our mission is to **promote growth** in the area of speech, occupational, physical therapy and general educational tutoring needs for **children between ages birth to 18 years** in a fun, family-friendly environment with a highly educated and experienced staff.

We are committed to providing **individualized and group** speech, occupational, physical therapy and tutoring services that will exceed the expectations of our patients and referring physicians.

We first will create an individualized plan for children of all abilities by **focusing on the whole child** through observation, diagnostics, coordination with your child's physician, specialist and school. Our highly skilled therapists focus on **family-centered care** in order to allow families to learn functional and fundamental techniques that will assist your child from the fun treatment room to their day-to-day life at home, in school, and even on the playground!

If you have any questions or concerns regarding your services, please make your therapist aware as they look forward to working closely with you!

Clinic Hours:
Monday-Thursday: 8am to 6pm
Friday: 9-1pm
*Hours subject to change

Phone: (248)-606-0551

Fax: (248)-926-5051

General Email: hello@fundamentaltherapies.com

Owner's Email: kristina.frimmel@fundamentaltherapies.com

Address:

1950 E. Wattles Rd
Suite 108
Troy, MI 48085

When you arrive to the building, please drive to the back of the building. We are located in the back center of the building.

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Registration Overview for Services

Documents Required for Services

- Completed Welcome Packet (this document)
- History and Intake Forms
  - Case History for Fundamental Therapies: Speech/OT/PT
  - Case History for Fundamental Feeding Therapies (if applicable for your child)

Please call our office (248)-606-0551 or email us at hello@fundamentaltherapies.com so that we can get to know a little more about you and your child's needs. We will then create an online portal through our electronic medical record system "Fusion Web Clinic" for you to complete your intake forms online.

*You also have the option of visiting our website at fundamentaltherapies.com clicking "Get Started" to download and complete our intake forms to bring with you to your initial evaluation.

Instructions for Accessing Your Patient Portal through "Fusion Web Clinic"

- Look for an email from "Fusion" to access your child's patient portal.
- Create an account with a Username and Password
- You will receive a notification that you have an intake form to fill out.
- Click to download the form and complete within the file.
- Once form is completed, click "upload form" to upload the form back to Fusion.

In addition to these forms we would like you to upload additional files pertaining to your child including, but not limited to:

- A copy of your insurance card (front and back)
- A copy of your Driver's license (front and back)
- A doctor's referral/script (Occupational, Physical and Speech Therapy services) including
  - Date
  - Patient name
  - Type of therapy to be received
  - Evaluation and treatment frequency (1-2x a week)
  - Diagnosis code (ICD 10)
  - Doctor's name, signature, and NPI #
- Copy of any Speech therapy, Occupational therapy, and Physical therapy evaluations completed within the last 12 months
- Copies of relevant IEP (Individualized Education Plan) or IFSP (Individualized Family Service Plan)
- Psychological or Behaviorist evaluations (including ABA services)
- Relevant imaging or physician reports impacting treatment
- Results of recent swallow studies
- Proof of guardianship if your child is in foster care or is under your care at the time of evaluation.

We will contact you within one business day after receiving your information. If for some reason you do not hear from us, please contact us at (248)-606-0551 or at hello@fundamentaltherapies.com.

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Electronic Signatures

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 Consent to Treat and/or any other new client documents. I understand that my email platform may not be HIPPA secure, and I consent to using email to send this information and to receive related communications from Fundamental Therapies. 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 acknowledgement and consent as does my physical signature.

_____

Patient Name

_____

Parent/Guardian's Name

_____ _____

Parent/Guardian Signature Date

If sending your welcome packet via Fusion Web Clinic, please complete the section below and sign below:

I have elected to electronically complete and/or submit the Welcome Packet and Consent to Treat and/or any other new client documents. I understand that Fusion Web Clinic is HIPPA secure. 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 acknowledgement and consent as does my physical signature.

_____

Patient Name

_____

Parent/Guardian's Name

_____ _____

Parent/Guardian Signature Date

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Non-Guardian Authorizations

I hereby inform Fundament Therapies that the people listed below are authorized to accompany my child at any time, receive private health information (PHI) feedback, and/or receive health documents. Accordingly, Fundamental Therapies 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:

- Parent/guardians must inform Fundamental Therapies of the name of the person who is accompanying their child on any day when they themselves are not.
- The authorized 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.

_____ _____

Parent/Guardian Signature Date

_____ _____

Relationship to Patient Patient Name

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Confidential Exchange/Release of Information Form

To facilitate integrated services for your child, we recommend that copies of evaluations and other written reports be shared with other professionals in your child's life (i.e. teacher, pediatrician, psychologist, tutor, etc.). It is important for us to be able to maintain good communication with people working with your child. This release would remain in effect for one year and authorizes the clinic to send your child's written reports and/or have verbal conversations to/with outside professions.

Please initial next to selected options below:

____I hereby authorize Fundamental Therapies to release written Occupational, Speech, and/or Physical Therapy reports of my child, to the agencies or professionals listed below.

____I hereby authorize Fundamental Therapies to have verbal contact to the agencies or professionals listed below.

____I DO NOT authorize Fundamental Therapies to communicate in writing or verbally to outside agencies/professionals.

_____ _____

Parent/Guardian Signature Date

_____ _____

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Agencies/Professionals

Please list the names and complete addresses, phone numbers and/or fax numbers of agencies/professionals that you would like to receive copies of your child's occupational/speech therapy reports.

Name	Address	Phone	Fax

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Media Release Form

Fundamental Therapies recognizes the need to ensure the welfare and safety of all individuals taking part in any activity associated with our company. As your child will be taking part in therapy at our clinic, we would like to ask for your consent to take photographs/videos that may contain images of your child.

It is likely that these images may be used as a record of therapy progress, a description of activities or exercises, marketing via social media (Facebook, Instagram, and/or company website), and records of activities or events in published materials. We will take steps to ensure these images are used solely for the purposes they are intended.

I _____, grant permission to Fundamental Therapies to use my child's image (photographs and/or video) for use in Media publications including:

Please check all that apply:

_____Videos

_____Marketing materials (email, flyer, brochure, etc)

_____Photographs

_____Instagram

_____Facebook

_____Fundamental Therapies Website

_____All of the above uses are approved.

_____None of the above uses are approved.

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, waive my right to royalties or other compensation arising from or related to the image, and agree to hold Fundamental Therapies harmless from any and all claims, costs, residuals, royalties, damages, and/or liabilities of any kind arising out of in or connection with the permission rights granted.

I acknowledge that I have read the above release and am familiar with its contents. I voluntarily agree to and give permission to Fundamental Therapies for use of video, photo, and written documentation of my child and for the above identified purposes.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Relationship to Patient Patient Name

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Clinic Expectations

- Please arrive 15-20 minutes early for your initial evaluation. This will ensure all paperwork is completed.
- Please be on time to your scheduled therapy appointment.
- Please be courteous and respectful of others in the clinic. Be mindful of the space and clean up after your child if a mess occurs.
- Parents with siblings must wait in the waiting room. **A parent/caregiver must remain on the premises during a therapy session.**
- The patient's parent/guardian must be present during the initial evaluation in order to consent to therapeutic treatment and provide additional information during the assessment process. Proof of guardianship must be provided if the child is in foster care at the time of the evaluation.
- The speech pathologist will treat your child for **25** minutes; the physical and occupational therapists will treat your child for approximately **45-55** minutes; all questions will be answered in the remaining timeframe of your allotted 30 minute or 60 minute session. Please be respectful of the next patient's time.
- Our mission is to promote growth in the areas of speech, occupational and physical therapy. Our therapists are trained in managing behavior and safety techniques; however, the intention of a therapy session is to progress towards meeting established therapy goals within the respective discipline of service. We do not have a behavioral therapist on staff in our clinic, and therefore do not provide behavioral therapy within your child's session. If your child demonstrates behaviors such as aggression towards self or others and these behaviors negatively influence progress towards goals, a support person may be required to attend all therapy sessions. Your child may be asked to leave our care if we feel we cannot meet their needs or if the behaviors demonstrated pose too great of a risk to themselves or others. Our clinic will always remain a safe and therapeutic environment for all staff, patients, and families. We can provide resources for behavioral services if you are in need.
- If your child is seen by multiple disciplines, we recommend working with your therapists to schedule their appointments on the same day. This process greatly assists in collaboration between discipline providers for continuity of care and can also benefit insurance coverage when the number of visits provided are limited.
- **Services will be terminated when your child has received the maximum benefit from therapy. This will be determined by the primary treating therapist in conjunction with the caregiver(s), physician, and/or teachers.**
- **Recommendations provided by treating therapists are meant to assist in further development of your child's progress. It is the responsibility of our families to adhere to provided home exercise programs and activity recommendations to promote advancement of established therapy goals.**
- **If you have questions regarding treatment or therapeutic intervention approaches, we ask that you collaborate with your treating therapist to meet your needs.**
- Please contact your insurance to verify your benefits prior to treatment. This will assist us in providing seamless intervention for your child and prevent unnecessary interruptions in your care. Patient contracts with their insurance company are agreements between the patient and the insurance company, and Fundamental Therapies is not a party to it.

Thank you for your cooperation. These guidelines and responsibilities are intended to keep everyone safe and to ensure our clients are getting the most out of their therapy session.

_____ _____

Signature of Parent/Guardian Date

_____ _____

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Attendance Guidelines

Consistent attendance to therapy sessions is vital to continued progress toward your child's therapy goals.

- Our office should be notified 24 hours in advance when a patient cannot keep a scheduled therapy session other than for illness or emergencies.
- Patients must attend 75% of their sessions per month, calling or giving prior notification when canceling.
- Two no shows (a family does not inform the clinic of their absence prior to the appointment) are grounds for discharge.
- We will do our best to reschedule your appointment if your clinician if off.
- A child should be free from fever (without the use of fever reducing medications), nausea, colored mucus, flu-like symptoms and/or diarrhea for 24 hours prior to attending an appointment. Should your therapist deem your child unfit to receive treatment based on the above symptoms, your session will be cancelled and rescheduled.
- We ask that you please report cases of flu or other communicable illness to our staff within 24 hours of the last clinic visit.
- Should the clinic close due to unforeseen circumstances (i.e., inclement weather, power outage), we will notify you via text or phone call prior to your treatment time.

I have read and understand this policy.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Relationship to Patient Patient Name

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Payment Policy / Billing Guidelines

Fundamental Therapies is committed to providing you with quality care. The following is our payment policy.

_____Each patient/family is solely and individually responsible for all fees and services provided. Knowing your insurance benefits is your responsibility. Patient contracts with their insurance company are agreements between the patient and the insurance company, and Fundamental Therapies is not a party to it. Please contact your insurance company with any questions you may have regarding your coverage.

_____We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

_____Fundamental Therapies policy is to obtain a referral (prescription); it is your responsibility to provide the referral to our office prior to seeing any of our treating therapists. If unable to provide the referral prior to the visit, your visit will be cancelled and $25 fee for failure to obtain referral will be instated.

_____All patients must complete our Case History form before seeing a therapist. We must obtain a copy of a parent and/or legal guardian's driver's license and current valid insurance to provide proof of insurance.

_____We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contact between you and your insurance company; we are not a party to that contract.

_____In the event that your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

_____Fundamental Therapies charges a $25 fee for failure to cancel your appointment within 24 hours of your scheduled appointment time.

_____Interest fees may be applied to patient accounts exceeding 30 days past due. A fee of $25 will be charged for any returned check

_____Payment can be made by cash, check or credit card. Cash and check payments can be made directly at the front office. Checks can be mailed to 1950 E. Wattles Rd, Suite 108, Troy, MI 48085. Credit card payments (i.e., VISA, Mastercard, Discover and American Express) can be made over the phone or directly at the front office.

_____In order to service client accounts or to collect any amounts that are due, Fundamental Therapies and debt collection agencies may contact clients at any telephone number or email address associated with their account.

_____The adult who signs this policy will be responsible in full for payment.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

_____ _____

Relationship to Patient Patient Name