GALAXY
BRAIN AND THERAPY CENTER

WHERE NEUROSCIENCE
MEETS FUNCTIONAL OUTCOMES

5840 INTERFACE DR. STE 400
ANN ARBOR, MI 48103

734-627-8001 734-433-1989
WWW.GALAXYBRAINCENTER.COM

Galaxy Brain and Therapy Center Intake and Essential Documents

☐ New Client ☐ Annual Renewal of Signatures ☐ Change of Insurance/Address

First Name:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Preferred contact method for appointments. Please check all that apply:
☐ Home Phone Call ☐ Cell Phone Call ☐ Cell Phone Text ☐ Email

Would you like to be added to the Galaxy email list that includes helpful resources? ☐ Yes ☐ No

Emergency Contact Name:_____

Emergency Contact Number:_____

Have you had a change in your insurance this year? ☐ **Yes** ☐ **No**
*****If yes, please update insurance info below:**

Insurance Information - Please submit copy of health insurance cards.	
Primary Insurance Name:	
Subscriber Name:	**Subscriber DOB**:
Claim/Contract#:	
Adjustor Name (if Auto Insurance):	
Adjustor Contact (if Auto Insurance):	
Secondary Insurance Name:	
Subscriber Name:	**Subscriber DOB:**
Claim/Contract#:	
Adjustor Name (if Auto Insurance):	
Adjustor Contact (if Auto Insurance):	

Care Team for Release of Information

By filling out this form, you are allowing Galaxy Brain and Therapy Center's staff to provide medical treatment information to your care team. This allows us to work as a team with all of your providers to give you the best level of care:

☒ **I authorize Galaxy to share medical treatment notes/team communication, verbal and written, with the care team members listed below.**

Client/Guardian Signature:_____**Date:**_____

Printed Name:_____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other:** _____

EXPIRATION OF AUTHORIZATION - This authorization will expire 12 months after the date of my signing this form. **NOTICE**: Galaxy Brain and Therapy Center and many other health organizations are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

YOUR RIGHTS: This authorization to release health information is voluntary. Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) to conduct research related treatment; (2) to obtain information in connection with eligibility or enrollment in a health plan; (3) to determine an entity's obligation to pay a claim; (4) to create health information to provide to a third party.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your guardian/patient representative, and delivered to Galaxy Brain and Therapy Center, 5840 Interface Dr, Ste 400, Ann Arbor, MI 48103. The revocation will take effect when Galaxy Brain and Therapy Center receives form. You are entitled to receive a copy of this authorization.

Referring MD: ☒ Send monthly progress notes
Phone: Fax:
Address:

Primary Care Physician: ☐ Send monthly progress notes
Phone: Fax:
Address:

Psychological Services: ☐ Send monthly progress notes
Phone: Fax:
Address:

Neurology/Specialty: ☐ Send monthly progress notes
Phone: Fax:
Address:

Legal Counsel: ☐ Send monthly progress notes
Phone: Fax:
Address:

Guardian: ☐ Send monthly progress notes
Phone: Fax:
Address:

Conservator: ☐ Send monthly progress notes
Phone: Fax:
Address:

Case Manager: ☐ Send monthly progress notes
Phone: Fax:
Address:

Family Member(s): ☐ Send monthly progress notes
Phone: Fax:
Address:

Other: ☐ Send monthly progress notes
Phone: Fax:
Address:

Please check all that apply in order for our team to maximize your safety.

Equipment used for mobility: ☐ Cane ☐ Walker ☐ Wheelchair ☐ N/A

Precautions. Please check all that apply:

☐ Seizures ☐ Falls ☐ Confusion ☐ Hearing Loss ☐ Low Vision ☐ Caffeine Restriction
☐ Dietary Restrictions ☐ Diabetic Type 1 ☐ Diabetic Type 2
☐ Swallowing difficulty
☐ Food Textures:_____ ☐ Thicken Liquids:_____
☐ Other:_____
☐ Food Allergies:_____
☐ Pet Allergies:_____
☐ Environmental/Other:_____
☐ Allergies:_____

Patient Financial Responsibility Form

Thank you for choosing Galaxy Brain and Therapy Center (GBTC) for your rehabilitative needs. Our services imply a financial responsibility on the patient's part. We are pleased to assist the patient by verifying coverage and billing our contracted insurers. However, the patient is ultimately responsible for the payment of the bill. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities:

- The patient (or patient's guardian) is ultimately responsible for the payment for his or her treatment and care.
- The patient is required to provide us with the correct and updated information about their insurance and will be responsible for any charges incurred if the information provided is not current or updated.
- Patients are responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
- Patients may incur and are responsible for the payment of additional charges at the discretion of GBTC. These charges may include (but are not limited to):
    - Charge for returned checks
    - Charge for missed/cancelled appointments without 24-hour advance notice. **$25.00***

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Client/Guardian Signature:_____**Date:**_____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other:**_____

Waiver of Patient Authorizations (Sign if you do NOT want us to bill insurance for your services.)

I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

Client/Guardian Signature:_____ **Date**:_____

*This policy has been established in order to provide the highest level of therapy service to all of our clients. Consistent attendance at therapy appointments is an important contributor to the success of one's treatment. We understand that occasionally emergency situations arise that require a cancellation. However, when clients frequently cancel or fail to come to appointments, it interrupts the treatment process and takes away treatment opportunities for other clients. If an appointment must be cancelled, we require a 24-hour notice so the reserved time can be used for emergencies or clients on the waitlist. If a client fails to follow through with his or her therapy appointment or cancel with less than a 24-hour notice, a $25.00 late fee will be assessed. Additionally, if a client repeatedly cancels even with notification, the clinician will discuss with the client his or her current commitment level to ongoing treatment and discuss possible options such as discharge or putting therapies on hold to allow clients to be seen that are on our waitlist. However, there is no guarantee that the client would be working with the same therapist once they resume therapy. If cancellations continue to be a regular occurrence, the client may be discharged from services for failure to meaningfully participate in treatment.

Advanced Directives for Health Care (DNR, Living Will, etc.)

Do you have any advanced directives for your health care?

☐ Yes (Complete below) ☐ No (No need to complete below)

Primary Care Physician:_____

Explain Advanced Directives:_____

Notice of Privacy Practices

Acknowledgement of Receipt: By signing this form, you acknowledge that you have been offered a copy for review of Galaxy Brain and Therapy Center's Notice of Privacy Practices, which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Office Manager at 844.816.0226.

Client/Guardian Signature:_____**Date:**_____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other:**_____

General Consents and Acknowledgements

1. I consent to and hereby authorize Galaxy Brain and Therapy Center (GBTC) through its appropriate personnel, agents, and affiliates to perform the evaluation, care, and treatment procedures that are deemed necessary by my physician(s) and other healthcare providers (collectively my "Care"). I understand that no warranties or guarantees have been made to me about the outcome of my Care.
2. I understand that GBTC works with accredited academic institutions, through clinical affiliations, to provide healthcare professionals in training with hands-on patient care experiences and opportunities to apply learned skills to actual patient care. I further understand that such healthcare professionals in training may be involved in my Care.
3. I understand that GBTC will not be responsible for the loss, destruction, or theft of any of my personal property. I take full responsibility for, and release GBTC from, any and all responsibility and/or liability for the loss, destruction, or theft of my personal property at, or in the vicinity of, any GBTC location or clinic.
4. I understand and acknowledge that GBTC may lease or license real estate, equipment, or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively "Releasees") from, and hereby waive and release any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with, or while making use of the Leased Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise, and regardless of whether any such liability arises in tort, contract, strict liability or otherwise to the fullest extent allowed by law. This paragraph does not release any claims, demands, actions, and/or causes of action against GBTC.

5. I understand that I am not permitted to take pictures or make video or audio recording at any GBTC location or clinic of my care, other patients, or GBTC personnel.
6. I understand that to ensure that patient inquiries are handled promptly, courteously, and accurately, some of the phone calls between GBTC (or any of its affiliates, agents, assigns, and service providers) and me (or anyone I have authorized to speak with GBTC) may be monitored and/or recorded.
7. I understand and consent that GBTC may, from time to time, make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and/or the account holder. I understand and consent that the manner in which these calls or text messages is made may include, but is not limited to, the use of pre-recorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.
8. I understand and consent that GBTC may send emails to me at any email address provided to GBTC and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.
9. I understand and acknowledge that my appointed times are scheduled in accordance with availability of professional staff. I understand that my appointment may be rescheduled by GBTC if I arrive more than 15 minutes late. I also acknowledge that GBTC requires 24-hours advance notice of cancellation and that GBTC reserves the right to charge a $25.00 cancellation fee if I fail to cancel an appointment at least 24 hours in advance.

Client/Guardian Signature:_____**Date:**_____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other:**_____

Digital Communication Preferences

Galaxy Brain and Therapy Center offers our patients exciting ways to stay in touch with your treatment. Our digital service, or patient portal, is known as *Galaxy In Touch* located at: http://galaxyintouch.insynchcs.com/. The patient portal gives you easy visibility to important aspects of your treatment including progress toward your goals, access to your individualized home exercise programs, submitting paperwork, and managing appointment reminders, and more. Please take advantage of this valuable resource!

I understand that authorized personnel from GBTC may communicate with me regarding scheduling, the treatment being provided, insurance information, educational information including newsletters as it relates to health-related products or services available at GBTC, or alternative treatments, locations, or providers. I agree to receive such communication via email at the following email address. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time. This will also be the address used to access the patient portal, *Galaxy In Touch*:

Email address:_____

Client/Guardian Signature:_____**Date:**_____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other:**_____

ASSIGNMENT OF BENEFITS FORM

(COMPLETE ONLY IF YOUR CARE IS PAID FOR BY AUTO INSURANCE)

I request that payment of authorized no-fault insurance benefits be made on my behalf to Galaxy Brain and Therapy Center (GBTC) for any services provided to me by that organization. I assign and transfer the right to collect payment of the services provided by GBTC in exchange for valuable consideration including documenting, billing, and legal efforts by GBTC to collect such insurance benefits from the insurer. I grant GBTC the right to pursue claims directly against my insurance company for non-payment of the services provided by GBTC. This is not an assignment of future benefits. This Assignment only applies to past services provided by GBTC.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to GBTC.

Client/Guardian Signature:_____**Date:**_____

Printed Name:_____

Relationship to Patient: ☐ **Self** ☐ **Parent** ☐ **Guardian** ☐ **Other:**_____

Photograph and Video Release Form

I, hereby, grant permission to the rights of my image, likeness, and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational/marketing settings within an unrestricted geographic area.

Photographic, audio, or video recordings may be used for the following purposes:

- Conference presentations
- Educational presentations or courses
- Informational presentations
- Online presentations
- Educational videos
- Promotional materials
- Website design
- Blog
- Social media

By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting. I will be consulted about the use of the photographs or video recording for any purpose other than those listed above. There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. This release applies to photographic, audio, or video recordings collected as part of the sessions listed on this document only.

By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I, hereby, release any and all claims against any person or organization utilizing this material for educational purposes.

☐ I grant permission ☐ I do NOT grant permission

Client/Guardian Signature:_____Date:_____

Printed Name:_____

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Other:_____

If this release is obtained from a presenter under the age of 19, then the signature of that presenter's parent or legal guardian is also required.