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Equi-Librium THERAPY CENTER

CLIENT APPLICATION FOR HIPPOTHERAPY/THERAPEUTIC RIDING

Client Name _____ M ___ F ___ DOB _____ Parent(s)/Guardian (s) _____

Street Address _____ City _____ State _____ Zip Code _____ County _____

Phone: Home _____ Work _____ Cell _____ Email_____

Client's Physician _____ Physician's Phone _____ Preferred medical facility_____

Therapist (s) OT, PT, SLP _____ Therapist (s) Phone _____

CLIENT PHYSICAL INFORMATION

Allergies (ie, nuts, dogs) check one: No ____ Yes ____ Explain: _____

Client diagnosis/Disability _____ Date of Onset _____

Client Height _____ Client Weight _____ (*Equi-Librium Therapy Center has a **200 lbs. weight limit.** All clients are required to wear closed toed shoes. It is recommended to wear pants/tights to avoid rubbing on the saddle/bareback pads.*)

Verbal ___ Nonverbal ___ Communication Device _____ Ambulatory ___ Non-ambulatory ___ Wheelchair _____

Walker ___ Cane ___ Continent ____ Incontinent ____

Shunt ___ Date of last Revision _____ Other assistive devices (ie., AFOs, glasses)_____

Hx of Seizures Yes ___ No ___ Type & frequency _____Date of last seizure _____ Are seizures controlled? Yes __ No __

Current medications (type & amount) _____

EMERGENCY CONSENT (Initial only one below)

1. In the case of a medical emergency, the undersigned authorizes _____ to provide medical assistance as an
(Contact Name & Phone Number)
authorized individual determines to be necessary in the absence of parent/guardian. Initial here _____

2. In the case of a medical emergency, the undersigned does not consent to emergency medical treatment in the absence of a parent/guardian.

Initial here _____

PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND/OR SPEECH-LANGUAGE PATHOLOGY PROGRESS NOTES

(To be completed by current therapist - ONLY required if client is currently receiving therapy)

Client Name _____ DOB _____ Primary Diagnosis _____ Description _____

Other Relevant Medical/Birth History _____

Pain:		Developmental Balance-Protective Reactions:		Grasps:	Right / Left
Character		Forward		Rake	
Location		Backward		3 finger	
Caused by		Right side		Pincer	
Relieved by		Left side		Key	
Functional Abilities:		Coordination:		Olfactory:	
Mobility		Gross motor		Auditory:	
Transfers		Fine motor		Visual motor-tracking:	
ADL skills		Reflex Activity:		Visual:	
Muscle Strength:		Developmental		MVPT figure ground	
Gross		Tendon reflexes		Position in space	
Muscle tone		ATNR		Visual memory	
Specific weaknesses		STNR		Visual closure	
Joint ROM:		Cross extension		Spatial relationships	
Gross		Motor Planning:			
Specific limitations		Diadochokinesis		Sensory Impairments:	
Trunk Strength:		Rapid hand rotation			
Torso-prone extension		Finger opposition		Perceptual Problems:	

Supine flexion		Imitation of postures			
Scapular stability					
Balance:		Bilateral Hand Usage:		Communication Difficulties:	
Sitting		Simultaneously			
Standing		Separately			
		Midline crossing			
		Dominance in:		Skin condition(s):	
		Hand/Eye/Foot			

Plans and Goals:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Additional Comments:

_____ Date _____

Printed Name of PT, OT, or SLP

_____ Date _____

Signature of PT, OT, or SLP

PHYSICIAN PERMISSION

Equi-Librium Therapy Center provides equine therapy programs designed to benefit the participants both physiologically and psychologically. Certified and licensed therapist (PT, OT, and SLP), certified riding instructors, and volunteers facilitate the programs using safety equipment and specially trained horses. In order to assure the fullest possible protection and greatest personal benefit from the program, each client is required to furnish the following medical information before acceptance to *Equi-Librium Therapy Center*.

Client Name _____ DOB _____ Diagnosis _____ Date of Onset _____

NOTE: Because of the nature of the activity of horseback riding, no individual diagnosed with Down's syndrome can be accepted for riding instruction without proof of a negative diagnostic x-ray for Atlantoaxial Dislocation Condition. **If the diagnosis is Down's syndrome, this form must be accompanied by one of the following:**

a. Special Olympic Down's Syndrome Athletic Evaluation
b. Signed, dated statement from a qualified physician giving the date and result of a diagnostic x-ray for Atlantoaxial Dislocation Condition.

Medical History _____ Surgical Procedures _____

Deficiencies present in (check all that apply): Sight ___ Hearing ___ Speech ___ Neuro-sensation ___ Balance ___ Mobility ___ Coordination ___ Muscle Tone ___

IN MY OPINION THE ABOVE NAMED CLIENT MAY RECEIVE THERAPEUTIC HORSEBACK RIDING INSTRUCTION UNDER APPROPRIATE SUPERVISION.

Physician Signature _____ Date _____

Printed Name of Physician _____ Address _____ Phone _____

Physician Referral for PT, OT and or SLP Therapy

(ONLY required if client is applying for or currently receiving Hippotherapy)

Client: _____ DOB: _____ Primary Dx: _____ Secondary Dx:_____

Please check all that apply: □ **OT** □ **PT** □ **SLP**

Physician Signature _____ Date _____

Printed Name of Physician _____ Address _____ Phone _____

In the case of any medical change/status/or new procedure, the client must inform Equi-Librium Therapy Center staff and provide a NEW Physician Permission Form (signed and dated by the physician). Failure to provide this new form could result in dismissal. Until new paperwork is received, the client WILL NOT be allowed to get on a horse.

I agree to the policies of *Equi-Librium Therapy Center* as stated below. My initials by each item below indicates my understanding/acceptance.

PATIENT'S RIGHTS AND RESPONSIBILITIES

I, the undersigned, have read and understand the Patient's Rights and Responsibilities and understand the nature of the therapy services that the named client will receive. _____ Initial here

CONSENT FOR TREATMENT

I, the undersigned, hereby grant my permission for the above named client to receive treatment services at *Equi-Librium Therapy Center* as they have been outlined to me. _____ Initial here

FINANCIAL RESPONSIBILITY

Hippotherapy Clients: New clients will receive an evaluation which is **$80**. The fee for each therapy session thereafter is **$80 per hour (this is 45 minutes of direct therapy time - 1 hour total with mounting/dismounting)**. There will be a **$55 charge** for each additional written therapy report requested by client's family excluding service sheets completed at each therapy session**.**

Therapeutic Riding Clients: All clients will be charged **$250** for an 8 week session.

With Hippotherapy/Therapeutic Riding payment is required at the time of service, and not all insurance companies will reimburse for services. I understand that my insurance company may not reimburse for Hippotherapy as a treatment program. I, the undersigned, assume financial responsibility for the services that the named client will receive at *Equi-Librium Therapy Center*. _____ Initial here

CANCELLATION POLICY *(please read carefully)*

Hippotherapy Clients: the cancellation policy requires 24-hour notice except in the event of an emergency such as a sudden illness. **I UNDERSTAND THAT FAILURE TO NOTIFY *Equi-Librium Therapy Center* OF CANCELLATIONS 24 HOURS IN ADVANCE OF THE SCHEDULED SESSION WILL RESULT IN AN $80 CHARGE FOR THE MISSED SESSION.** I, the undersigned, agree to notify the Hippotherapy Coordinator via phone. **I understand that if three consecutive sessions are canceled there may be a loss of that scheduled time slot for the above named client** _____ Initial here.

Therapeutic Riding Clients: All clients must pay the whole fee of $250 for each 8 week session. In the event that ETC cancels a session, a make-up session will be offered. In the event ETC cancels therapy sessions due to inclement weather, holidays, etc.; clients will be notified via posting on the ETC website in addition to email or phone. I understand if ETC has not notified clients of a closing, therapy will be conducted as scheduled. _____ Initial here

Due to the popularity of Hippotherapy/Therapeutic Riding, we often have a waiting list. All current clients are insured their current time slots for their continual time of participation. Upon leaving the program during the year, their time slot MAY be filled from the waiting list. If wishing to return, clients will be informed of time slots as they open up throughout the year.

PHOTO RELEASE (Check appropriate blank)

For valuable consideration given and which is hereby acknowledged, the undersigned hereby _____**DO** grant or _____**DO NOT** grant to *Equi-Librium Therapy Center* permission to take or have taken, still and moving photographs and films including television pictures of _____ (client name) and consents and authorizes *Equi-Librium Therapy Center*, its news media, and other persons interested in *Equi-Librium Therapy Center* and its work, to the use and reproduction of the photographs, films, and pictures to circulate and publicize the same by all means including without limit, the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional materials, books and clinical material. With regard to the foregoing material, no inducements or promises have been made to us/me to secure our/my signature(s) to the release other than the intention of *Equi-Librium Therapy Center* to use such photographs, films and pictures for the primary purpose of promoting and aiding its program and its work. _____ Initial here.

NON DISCRIMINATION POLICY

Equi-Librium Therapy Center does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by *Equi-Librium Therapy Center* directly or through a contactor or any other entity with which *Equi-Librium therapy Center* arranges to carry out its programs and activities. This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91. _____ Initial here

GRIEVANCE POLICY

It is the intent of *Equi-Librium Therapy Cente*r to provide all clients with quality treatment services. In the event, a client or his/her parent or legal guardian has a complaint pertaining to any and all aspects of the services provided at *Equi-Librium Therapy Center,* the individual is required to submit a written complaint to the Executive Director, Kent Crumpley. A response to complaint, both in writing and through personal contact if such contact is possible, will occur within two weeks of receipt of complaint. _____ Initial here

LIABILITY RELEASE

WARNING: Under Missouri law, an equine professional is not liable for an injury to or death of a participant in equine activities resulting from the inherent risks of equine activities pursuant to the Revised Statutes of Missouri Chapter 537 Section 537.325. As a client of *Equi-Librium Therapy Center*, I acknowledge the risks and potential risks of a horseback riding program. However, I feel that the possible benefits are greater than the risks assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever, acquit, discharge and hold harmless the *Equi-Librium Therapy Center,* its officers, trustees, agents, employees, representatives, successors and assigns, for all manner of claims, demands and damages of every kind and nature whatsoever, which the undersigned or said minor may now, or in the future, have against the *Equi-Librium Therapy Center* its officers, trustees, agents, employees, representatives, successors or assigns on account of any personal injuries, physical or mental condition, know or unknown, to the person of said minor and the treatment therefore as a result of, or in any way growing out of, the acts of the *Equi-Librium Therapy Center* its officers, trustees, agents, employees, representatives, successors or assigns, including, but not limited to, their negligence or gross negligence, in rendering the services above described or in any way incidental thereto.

Date _____ _____ _____

Printed Name of Parent/Guardian or Self if over 18 Signature of Parent/Guardian or Self if over 18

NOTICE OF PATIENT INFORMATION PRACTICE

I have read and fully understand the *Equi-Librium Therapy Center* **Notice of Patient information practice.** I understand that *Equi-Librium Therapy Center* may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. "I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice." I also understand that *Equi-Librium Therapy Cente*r will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I understand this information will follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in regard to release of medical records and file records. (See following authorization for release of medical records and file records form) _____Initial here

The undersigned certifies that he/she has read and understands the foregoing statements regarding Patient's Rights, Consent for Treatment, Financial Responsibility, Cancellation Policy, Photo Release, Non-Discrimination Policy, Grievance Policy, Liability Release, and Notice of Patient Information Practice. The undersigned certifies that he/she is either the parent or duly authorized guardian of the named client or is in fact the named client and can execute the above policies thereby agreeing to abide by them.

Date _____ _____ _____

Printed Name of Parent/Guardian or Self if over 18 Signature of Parent/Guardian or Self if over 18

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND FILE RECORDS

To: _____ (Health Care Provider)

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. §164.508, you are hereby directed to furnish to *Equi-Librium Therapy Center* any information requested by them including, but not limited to:

* Hospital Records	* Emergency Room Records	*Ledger Cards	*EMT Reports
*Physical Therapy Records	*Medical Records	* Administrative Files	*Billing Slips/Forms
*X-Rays	*Progress Reports	*File Notes	*File Correspondence
*Test Results	*Doctor's Notes	*Pharmacy Records	
*Nurse's Notes	*Hospital Admissions/Discharges	*Insurance Forms (Health, Workmen's Compensation, etc.)	

or any other data in your possession, including your complete records file, which is related to my whole body, and permit the reproduction thereof, from _____ to present.

The purpose of this authorization and request is to allow *Equi-Librium Therapy Cente*r to access and obtain all medical records and other documents related to the aforementioned areas and conditions of my body and mind. You may discuss my condition, care and treatment with a representative of *Equi-Librium Therapy Center*.

Except to the extent that action has already been taken in reliance on this authorization, I can revoke this authorization at any time by submitting a notice in writing to the health care provider named above.

Unless revoked, this Authorization will expire one (1) year from today's date shown below.

I understand that my medical or billing records may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information, and I agree to its release.

I understand that the information disclosed by this authorization may be re-disclosed by the recipient and no longer be protected by HIPAA of 1996. The above-named health care provider and all of its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand the health care provider named above may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. A copy of this Authorization shall be regarded as an original.

Patient Information

Name: _____ SSN: _____ DOB: _____

_____ Date: _____

Signature of Parent/Guardian or Self if over 18