therapy services- RO

☐ **chatsworth**
21126 chatsworth street
chatsworth, california 91311
818.700.2971 ph
818.700.7803 fx

☐ **newbury park/thousand oaks**
401 ronel court
newbury park, california 91320
805.375.9078
805.375.8640 fx

Patient's Application and Health History
to be completed by the patient, or parent/legal guardian

GENERAL INFORMATION

Patient: _____
Date of Birth: _____ Age: _____Height: _____ Weight: _____ M F
Address: _____
Phone: (___)_____ Alternative: _____
Email: _____
Employer/School: _____
Address: _____
Phone: (___)_____
Parent/Legal Guardian: _____
Address (if different from above): _____
Phone: _____
Referral Source: _____
Contact numbers: _____
How did you hear about us? _____ _____

HEALTH HISTORY
Diagnosis: _____
Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other			

--- OVER ---

What medications are you currently taking, including over the counter medications? _____
_____
_____ _____

Describe your abilities/difficulties in the following areas, include assistance required or equipment needed:

FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

_____
_____
_____
_____
_____
_____
_____

SOCIAL (i.e. Work/School including grade completed, leisure interests, relationships - family structure, support systems, companion animals, fears/concerns, etc. . .)

_____
_____
_____
_____
_____
_____

GOALS: (i.e. What would you like to accomplish through therapy?)

_____
_____
_____
_____
_____
_____

PHOTO RELEASE

I consent to and authorize the use and reproduction by therapy services-RO of any and all photographs and any other audio-visual materials taken of me/of my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

CONSENT FOR CARE AND TREATMENT

I, the undersigned hereby agree and consent for therapy services - RO to furnish care and treatment considered necessary and proper in treating my condition.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

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Patient's Authorization for Emergency Medical Treatment

Please Print Clearly

Patient's name: _____ Date of Birth: _____ Phone: _____
Address: _____
Diagnosis: _____
Physician's Name: _____ Medical Facility: _____
Physician Address/phone: _____
_____
_____
Health Insurance Co: _____ Policy #: _____
Allergies to medications? _____
Current medications: _____

In the event of an emergency, contact:

Name:	Relation:	Phone:
Name:	Relation:	Phone:
Name:	Relation:	Phone:

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, and the above cannot be reached, I authorize therapy services or Ride On to:

1. Secure and retain medical treatment and transportation if needed.
2. Release patient records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person above is unable to be reached.

Date: _____ Consent signature: _____
Patient, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____
_____
_____

Date: _____ Non-consent Signature: _____
Patient, Parent or Legal Guardian

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.

--- OVER ---

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Participants Release and Hold Harmless Agreement

This Release Limits our Liability. Read it!!!

By signing this form, I acknowledge that equine assisted activities is a dangerous activity which may result in injury to me, my horse, or my equipment. With this knowledge, in consideration of the services of Ride On Therapeutic Horsemanship and Therapy Services – RO (Ride On) and as inducement for the services of Ride On to provide equine assisted activities to me, I hereby waive release, discharge and hold harmless Ride On, its officers, directors, employees and volunteer assistants, their heirs, executors, administrators, successors or assigns, from any and all liability for damages sustained by me, my family, any animal owned or controlled by me, or for any item or personalty under my dominion and control. Without limiting the generality fo the above, I hereby waive and release Ride On, its officers and directors, employees and all volunteer assistants for liability based on the active or passive negligence of said persons and entities.

I hereby agree to indemnify and hold harmless Ride On, its officers, directors, employees and all volunteer assistants associated therewith for any claims which may be made against them, including attorney's fees and costs of suit in any action based upon or arising from my acts or omissions, or the actions of any animal within my control.

This release extends to all claims, whether presently known or unknown. I hereby expressly waive any benefits I may have pursuant to Section 1542 of the California Civil Code relating to the release of unknown claims, which provides:

"A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release which if known by him must have materially affected his settlement with the debtor."

I acknowledge that I have read the foregoing and understand the contents thereof.

Dated: _____ _____

Dated: _____ _____ (witness)

MINORS MUST HAVE THE FOLLOWING SIGNED BY THEIR PARENTS OR LEGAL GUARDIANS

I, the undersigned, parent or guardian _____ of _____
for and in consideration of our child's participation at Ride On Therapeutic Horsemanship state that I have read the waiver, release and hold harmless written above and I expressly agree that the terms and conditions of said waiver, release and hold harmless shall apply to and be binding upon me and my minor child or his or her horse may sustain or cause as a result of said participation. I further warrant I have health and accident insurance for said minor.

Dated: _____ _____(parent/legal guardian)

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Payment Agreement

Session:

Patient:

Parent/Guardian:

Address:

Phone:

I understand that Therapy services that include hippotherapy cost, on average, $90 per treatment. I intend to assure payment to Therapy Services at Ride On in the following manner:

(please check all that apply)

___ Cash/Check/credit card
- ___ per treatment – billed ($90 per treatment)
- ___ paid at time of treatment (cash discount - $75 per treatment)
- ___ paid per session (7-8 treatments per session – total will vary depending on length of session, equivalent to $75 per treatment, cancelled treatments will be credited towards future treatments)
- ___ I intend to submit for reimbursement from my medical insurance and will need receipts/superbills. I understand that I am responsible to verify insurance coverage/potential exclusions of coverage with my insurance company directly.

___ Regional Center
- ____ North Los Angeles
- ____ Westside – Los Angeles
- ____ Ventura – Tri-counties
- ____ Other _____

Case worker's name/phone: _____

___ Scholarship – must be pre-approved, submit separate scholarship application

___ Other, please describe:

I understand that there is a cost involved in getting staff and horses prepared for each treatment, and realize that I may be charged 50% of the treatment fee if I do not show for an appointment and do not call. Exceptions are made for extenuating circumstances, as discussed with the program director or treating therapist.

I will notify the therapist or Program Director of any changes in the above information so appropriate arrangements can be made for payment.

_____ _____

signature – patient or parent/guardian date

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Scholarship Application Form

Ride On is happy to provide partial scholarships for our patients who may require financial assistance whenever funds are available. Please submit the completed application (including necessary attachments) to Ride On, Scholarship Fund, 21126 Chatsworth St., Chatsworth, CA 91131, Fax: 818.700.7803 at least 4 weeks prior to the beginning of the session. You will be notified by 2 weeks prior to the session if the application is approved. This application must be re-submitted each time a scholarship is requested.

Participant's Name: Date of Birth:

Address:

Home Phone: Cell Phone: Email:

Parent/Guardian:

Occupation: Work Phone:

Spouse's Occupation: Work Phone:

Responsible Party:

Address (if different from above):

Phone:

The following information will help Ride On to determine eligibility for scholarship funds. All identifying information on scholarship application forms is kept strictly confidential.

Family Income: # in Family (adults/children):

What extenuating circumstances/financial burdens exist? (for example, other siblings with a disability? financial support of other family members, recent job loss, etc . . .)

Are additional third party funds available to support this participant (i.e. regional center funding, private insurance, grants, etc . . .)

--- OVER ---

Ride On solicits funding through a variety of sources including grants, private donors, and philanthropic organizations. At any time, there may be a variety of funding sources. Scholarships are granted based on the requirements of the donor and are distributed on a first come, first served basis. Check the Ride On website for new sources of funding (www.rideon.org) as they come available.

Scholarship Requested (please check all that apply):
__ General funds (qualifies for all of Ride On's services, need based, requires submission of State/Federal tax forms for the past two years and proof of need along with this application)

Session that funds are requested for (circle one):
__ Winter 2007 __ Spring 2007 ___ Summer 2007 ___ Fall 2007

-Is this the first time participating at Ride On? Y / N

-Is this a renewal application? If so, please indicate the benefits received from the previous scholarship and the reasons why the scholarship is being requested again. . . .

_____
_____
_____
_____
_____
_____

If funds are received from a private donor, may Ride On release the name/photo of the recipient? Y / N

**Scholarships will cover part of the cost of therapy. Payment for the portion not covered by the scholarship is expected at the time of service. A new scholarship application form must be submitted quarterly. Amount of scholarship may vary based on fund availability.

**Ride On expects that scholarship recipients and/or their parent/guardian support Ride On. This could be done in a number of different ways. Examples include: work around the ranch or in the office, soliciting donations, serving on Ride On committees, or working at special events. Please check all areas in which you could help:
__ Ranch work __ Office/clerical __ Handyman services
__ Soliciting donations of goods or services __ Fundraising committee __ Special Events
__ Other _____

I have read and understand the scholarship application and the requirements for receipt of the scholarship and would like to be considered for scholarship.

Signature: _____ Date:

for office use only:
Session: Scholarship type:
Amount granted: Date notified:

Therapy Services - RO

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION

PLEASE REVIEW IT CAREFULLY

Therapy Services – RO is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Therapy Services- RO uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; fundraising and grant writing and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide schedule reminders, be included in statistics for fundraising, or provide other health related benefits that could be of interest to you.

Therapy Services - RO may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Therapy Services - RO policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Therapy Services - RO may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorize by you, when required by law or in emergency circumstances. Therapy Services - RO will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that Therapy Services - RO may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Therapy Director at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Therapy Services - RO health information practices or if you have a complaint, please contact:

Therapy Services at RO – Chatsworth
Gloria Hamblin, Program Director
Joann Benjamin, PT, Therapy Director
21126 Chatsworth Street
Chatsworth, CA 91311
818.700.2971
rideon@rideon.org

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Patient Information Acknowledgment Form

I have read and fully understand Therapy Services - RO Notice of Information Practices. I understand that Therapy Services - RO 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, payment or fundraising. 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 Therapy Services – RO will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Therapy Services - RO Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying Therapy Services – RO in writing at any time.

_____
Patient

_____
Signature of Patient, or Patient's Parent/Guardian if Minor

_____
Date

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PRESCRIPTION

Patient: _____ **Date:** _____

Address: _____

Phone: _____ **Date of Birth:** _____

Diagnosis: _____ **Date of Onset:** _____

PHYSICAL THERAPY	OCCUPATIONAL THERAPY
☐ **physical therapy evaluation**	☐ **occupational therapy evaluation**
☐ **physical therapy treatment**	☐ **occupational therapy treatment**
☐ **gait training**	☐ **ADL/home care training**
☐ **balance training**	☐ **therapeutic exercise/activities**
☐ **mobility skills**	☐ **cognitive skills**
☐ **strength training**	☐ **neuromuscular re-education**
☐ **coordination training**	☐ **visual/perceptual training**
☐ **neuromuscular re-education**	☐ **coordination training**
☐ **therapeutic exercise**	☐ **sensory integration**
☐ **other:** _____	☐ **other:** _____

Frequency: _____ **Duration:** _____

Precautions/Comments: _____

_____

_____

PLEASE PRINT

Name/Title: _____ MD DO NP PA other _____

Signature: _____ Date: _____

Address _____ City: _____ State: _____ Zip: _____

Phone: (___)_____ License/ UPIN Number:_____

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PATIENT'S MEDICAL HISTORY AND PHYSICIAN'S STATEMENT

Name: _____ Date of Birth: _____ Height: _____ Weight: _____
Address: _____
Diagnosis: _____ Date of Onset: _____
_____
Past/Prospective Surgeries: _____
Medications: _____
Seizure Type: _____ Controlled: Y N Date of last seizure: _____
Shunt present: Y N Date of last revision(s): _____
Date of last Tetanus Shot: _____
Special Precautions/Needs: _____
_____
Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N
Braces/Assistive Devices: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/ psychological			
Pain			
Other			

To my knowledge there is no reason why this patient cannot participate in therapy using the movement of the horse/hippotherapy. I understand that therapy services will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (PT, OT, SLP) in the implementation of an effective therapy program. **PLEASE PRINT**

Name/Title: _____ MD DO NP PA other _____

Signature: _____ Date: _____