Therapy Services

10860 Topanga Canyon Blvd, Chatsworth CA 91311 401 Ronel Court Newbury Park CA 91320

Fax: (805) 309-5234 Office: (818) 700-2971 www.rideon.org

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: _____ Gender:_____

Address: _____

Phone: (___)_____ Alternative: _____

Email: _____

Parent/Legal Guardian: _____

Primary Language spoken at home_____ Secondary Language_____

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			

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

_____

_____

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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, dressing, toileting, communication)

_____

_____

_____

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?)

_____

_____

_____

Therapy & Location: Please indicate your preferred therapy and location from our open slots (☐).

Therapy:	**Location:**
☐ Physical Therapy	☐ Newbury Park
☐ Occupational Therapy*	☐ Chatsworth
☐ Speech Therapy*	

*** Occupational Therapy and Speech Therapy only available in Chatsworth**

MEDIA/PHOTO RELEASE

I **CONSENT** / **DO NOT CONSENT** (circle one) 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/my child for research, promotional material, social media, 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

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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 and KEEP THIS COPY FOR YOUR RECORDS.

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-RO – Chatsworth
Sunny Holmes, Director of Therapy Services
818.700.2971
sunny@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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Payment Agreement

Patient: _____

Parent/Guardian: _____

Address: _____

Email: _____ **Phone:** _____

I understand that Therapy Services cost, on average, $120 per treatment. I intend to assure payment to Therapy Services-RO in the following manner:

Required Information

E-check – Checking ☐ **Savings** ☐

Account Number: _____

Routing Number: _____

OR

Credit Card – Master Card / Visa / Amex / Discover

Name on card: _____

Number: _____

Expiration: _____ Security Code: _____ Billing Zip code: _____

___ 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.

Cancellation Policy

I understand that there is a cost involved in getting prepared for each treatment and realize that I may be charged a $45 fee if I do not show for an appointment and/or do not cancel within 12 hours of the scheduled appointment. Late cancellations do not allow Ride On to schedule another patient who could benefit from therapy. I understand that I must send an email to cancellations@rideon.org at least 12 hours prior to the scheduled appointment in order to avoid being charged the $45 late cancellation fee. Exceptions are made for extenuating circumstances, as discussed with the Director of Therapy Services. I will notify the Director of Therapy Services of any changes in the above information so appropriate arrangements can be made for payment.

I acknowledge that I read the above agreement. I authorize Ride On to charge the above account for therapy sessions and any incurred late cancellation or no-show fees.

_____ _____

Signature – patient or parent/guardian Date

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Patient/Participant Release and Waiver of Liability
Assumption of Risk and Indemnity Agreement

Whereas, _____,
(Patient/Participant's Full Name – Please Print)
will be participating in therapy treatment sessions organized by Ride On L.A., a California non-profit corporation doing business as "Ride On", "Ride On Therapeutic Horsemanship", and "Therapy Services – RO" (hereinafter referred to as "Therapy Services-RO") ;
Please initial one of the following:

_____ Now, therefore, I, the undersigned *parent or legal guardian of the Patient/Participant* named above who is under 18 years of age, for myself and on behalf of the patient/participant named above, his or her personal representatives , estate, heirs, assigns, and next of kin,

_____ Now, therefore, I, the *Patient/Participant* named above, am 18 years of age or older, and I, my personal representatives, estate, heirs, assigns, and next of kin,

do **hereby agree to give up any and all of my legal rights** against Therapy Services-RO, its agents, employees, participants, officers, directors, representatives, assigns, members, owners of riding premises and trails used in its therapy treatment sessions, affiliated organizations, people with whom it has contracts to provide facilities or services, insurers, and others acting on its behalf ("hereinafter collectively referred to as "RELEASED PARTIES"), as more specifically indicated below:

Acknowledgement of Danger and Assumption of Risk.

I acknowledge that physical or occupational therapy incorporating equine movement, being near horses, and being at equestrian facilities and on trails, is **inherently dangerous**, and that no amount of care, caution, instruction, or supervision can eliminate such **dangers.**

I acknowledge such **dangers** include, but are not limited to the following:

1. A horse that may, among other things, buck, stumble, fall, rear, bite, kick, run, stomp, make unpredictable movements, spook, jump obstacles, step on a person's feet, and push or shove a person; saddles, bridles, or other equipment that may loosen, break, or otherwise malfunction; other riders who may not control their animals or ride within their ability, and cause a collision or other unpredictable consequence.
2. The negligent or intentional act or omission of RELEASED PARTIES or a third party.
3. Therapy sessions incorporating equine movement that may be conducted in areas that are subject to change in condition according to weather, temperature, and natural and man-made changes in landscape.
4. An apparent or hidden defect or dangerous condition of the equestrian facilities and trails.

Any of these and other known or unknown **dangers** may cause me to fall or be jolted or injured in another manner, resulting in the possibility of **serious physical and emotional injury, and death**. In addition, I acknowledge that such **injury and death** could result from **self-inflicted injury and death**. **Despite such dangers, I voluntarily assume the risk and danger of serious injury and death inherent in all therapy sessions which may or may not incorporate equine movement organized by Therapy Services-RO.**

Helmet Requirement.

Therapy Services-RO is committed to providing excellent services in the safest environment possible. Wearing a helmet while mounted is required for all patients/participants at Therapy Services-RO. In several instances, helmets that are designed for equestrian use certified by ASTM*/SEI are not appropriate for our patients – due to fit, excessive weight or because of sensory issues. In those situations, we choose the next safest option which are helmets designed for other sports such as bicycle riding. Helmet testing is specific to the intended use. For example, bicycle helmets are certified by the CPSC (Consumer Products Safety Commission) and are tested for impact as might occur in a bike riding accident, but are not tested for situations that may arise from an equestrian accident. If bicycle helmets don't work, alternate helmet options may exist and be appropriate for you or your child.

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When an ASTM*/SEI equestrian helmet is not appropriate, we will review alternatives with you. It is important to note that no helmet is able to provide protection from all injuries. The patient/family is welcome, and encouraged, to provide a personal helmet for use during Therapy Services. We require that an ASTM/SEI equestrian helmet be chosen when possible. If a non-ASTM/SEI approved helmet is used, such use must be approved by the therapist. If at all possible, the helmet used should be certified by the appropriate agency.

Release of Liability.

I agree to **hold harmless, release and discharge** RELEASED PARTIES **from all claims, demands, causes of action, and legal liability** that I may hereafter have for **injuries, damages, and death** related to Therapy Services-RO incorporating equine movement including but not limited to **injury, damages, and death** caused by the negligent or intentional acts or omissions of RELEASED PARTIES or third parties.

I shall **not bring any claims, demands, legal actions, and causes of action** against Released Parties for **injury, damage, death, or other losses** sustained by me in relation to Therapy Services-RO treatment sessions which may or may not incorporate equine movement.

Indemnification.

I agree to **indemnify and hold harmless** RELEASED PARTIES as to all **claims, actions, damages, costs and expenses, including attorney's fees sustained**, as a result of my willful misconduct or gross negligence relating to my participation in Therapy Services-RO.

California Law.

This agreement is governed by the Laws of the State of California. In the event that any portion of this agreement is determined to be invalid, illegal, or unenforceable, the validity, legality and enforceability of the balance of the agreement shall not be affected or impaired in any way and shall continue in full legal force and effect.

I HAVE READ THIS RELEASE AND WAIVER OF LIABILITY ASSUMPTION OF RISK AND INDEMNITY AGREEMENT; I FULLY UNDERSTAND ITS TERMS AND UNDERSTAND THAT I AM GIVING UP SUBSTANTIAL RIGHTS BY AGREEING TO IT.

Patient/Participant Name _____Phone_____

Emergency
Contact _____ Phone _____ Relationship: _____

Patient/Participant's Signature: _____ Date _____
(Please sign if 18 or older)

Parent/ Legal Guardian _____ _____ Date _____
(Parent signature if under 18) (Please Print Name)

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Enrollment Intake Form

Therapy Services-RO provides over 500 Scholarship treatment sessions per year. The income and ethnicity information below is critical when we pursue funding sources, seek support for scholarships and to determine eligibility for public services funded by the City of Los Angeles. We treat this information with complete confidentiality and only report broad statistics, never personal data**.**

Patient Name: _____

Address:_____ City: _____ ZIP: _____

Phone Number:_____ DOB: _____ Gender: Male ☐ Female ☐

Family Size	B	C	D	E
1 Person	$0 - $23,700	$23,701 - $39,450	$39,451 - $63,100	$63,101+
2 Persons	$0 - $27,050	$27,051 - $45,050	$45,051 - $72,100	$72,101+
3 Persons	$0 - $30,450	$30,451 - $50,700	$50,701 - $81,100	$81,101+
4 Persons	$0 - $33,800	$33,801 - $56,300	$56,301 - $90,100	$90,101+
5 Persons	$0 - $36,550	$36,551 - $60,850	$60,851 - $97,350	$97,351+
6 Persons	$0 - $39,250	$39,251 - $65,350	$65,351 - $104,550	$104,551+
7 Persons	$0 – $41,950	$49,951 - $69,850	$69,851 - $111,750	$111,751+
8 Persons	$0 - $44,650	$44,651 - $74,350	$74,351 - $118,950	$118,951+

Disability	**Education Level**	**Customer Family**
☐ Disabled Adult (16+) ☐ Disabled Child (Under 15) ☐ None	☐ 0 - 8th Grade _____ ☐ 9 - 12th Grade _____ ☐ 2 or 4 Year College Degree ☐ High School Grad / GED	☐ Single Adult ☐ Two Adults No Children ☐ Single Parent ☐ Two Parent Family
Race ☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Pacific islander ☐ White	☐ Asian and White ☐ Black and White ☐ American Indian and Black ☐ Balance/Other	**Ethnicity (Check One)** ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Therapy Services-RO provides over 500 scholarship treatment sessions per year. The income and ethnicity information above is critical when we pursue funding sources, seek support for scholarships and to determine eligibility for public services funded by the City of Los Angeles. I certify that the information on this form is accurate and complete.

Patient Name: _____

Signature (parent if needed): _____ Date: _____

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PRESCRIPTION

Patient: _____ **Date:** _____

Address: _____

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

ICD 10/Diagnosis: _____ **Date of Onset:** _____

PHYSICAL THERAPY	OCCUPATIONAL THERAPY
☐ **physical therapy evaluation** ☐ **physical therapy treatment**	☐ **occupational therapy evaluation** ☐ **occupational therapy treatment**

SPEECH/LANGUAGE THERAPY

☐ **speech/language therapy evaluation**
☐ **speech/language therapy treatment**

Frequency: _____ **Duration:** ___ ☐ 1 year _____
___ ☐ other _____

Precautions/Comments: _____

_____

_____

PLEASE PRINT

Name/Title: _____ MD DO NP PA other _____

Signature: _____ Date: _____

Address _____

City: _____ Zip: _____ Phone: (_____)_____

Fax: (_____)_____License/ UPIN Number:_____

Email: _____