

PATIENT PACKET



1591 Big Branch Rd.
Middleburg, FL 32068
(904) 291-6784

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PATIENTS RIGHTS

A patient's bill of rights is established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her family, and our treatment team. The following rights of each of our patients will be upheld:

- To be fully informed prior to or at the time services are initiated of these rights and of all of the regulations and procedures governing treatment services at this facility.
- To be fully informed at the time of initial service of the services available at at this facility and of the fee schedule for such services.
- To be fully informed by the treatment professional involved as to the nature and scope of the treatment services to be provided.
- To refuse treatment at any time.

To be assured confidential treatment of personal, medical, and treatment records and to approve or refuse their release to any individual outside of this facility, except as required by law of third-party payment contract.

- To be treated with consideration, respect and full recognition of dignity.
- To be assured that the personnel who provide treatment are licensed and qualified through education and experience, to carry out the treatment services for which they are responsible.
- To receive prompt response to all reasonable inquiries.
- To be afforded the opportunity to participate in the planning of his/her treatment wherever possible.
- To be provided information about his/her handicapping condition so that he/she can participate more fully in the Treatment Plan.
- To have the right to voice concerns about the Treatment Plan without fear of restraint or discrimination.

The staff at HOPE THERAPY is committed to providing the best treatment program possible for each of our individual patients. We are pleased to have the opportunity to work with you and/or your family.



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Rider's Consent for Release of Information HOPE THERAPY

I hereby authorize: _____

to release information from the records of: _____
(Client's Name)

The information is to be released to: **HOPE THERAPY**

for the purpose of developing a Therapeutic Riding Program for the above named student. The information to be released is marked below.

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Classroom Individual Education Plan(I.E.P.)
- Other: _____

Date: _____ Signature: _____
(Client, Parent or Guardian)

Please send the indicated material to: **HOPE THERAPY**



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Rider's Registration and Release Form

Registration

Client: _____ Date of Birth: _____ Age: _____

Street: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Work Phone: _____ Emergency: _____

Parents or Guardian: _____

Address/Phone: _____

School or institution presently attending: _____

In case of emergency contact: _____ Phone: _____

contact: _____ Phone: _____

Liability Release

_____(Client's Name) would like to participate in the HOPE THERAPY Hippotherapy program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators waive and release forever all claims for damages against HOPE THERAPY Hippotherapy Its Board of Directors, Instructors, Therapists, Aids, Volunteers and/or Employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Hope Therapy. A Hippotherapy program.

Date: _____ Signature: _____

Client, Parent or Guardian

Photo Release

I hereby consent to and authorize the use of reproduction by Hope Therapy hippotherapy of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities of any other use for the benefit of the program.

Date: _____ Signature: _____

Client, Parent or Guardian



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Rider's Authorization for Emergency Medical Treatment Form

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, I authorize _____

(Operating Center's Name) to:

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

Client's Name: _____ Phone: _____

Address: _____

In the event I cannot be reached, contact: _____ Phone: _____

contact: _____ Phone: _____

Physician's Name: _____

Preferred Medical Facility: _____

Health Insurance Co.: _____ Policy #: _____

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 below is unable to be reached

Date: _____ Consent Signature: _____

Client, Parent or Guardian

Print Name: _____ Phone: _____

Address: _____

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 _____

Client, Parent or Guardian

Print Name _____ Phone: _____

Address: _____

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

INSURANCE INTAKE DATA

PATIENT NAME _____ INFO TAKEN BY _____

DATE OF APPT _____ APPT TIME _____ LOCATION _____

INSURANCE INFO: PRIMARY INS. SECONDARY INS.

TYPE: PIP W/C COMM MDCR MDCD HMO PPO OTHER

INSURED: _____

EMPLOYER: _____

INSURANCE CO.: _____

ADDRESS: _____

INS. CO. PHONE: _____

ADJUSTER: _____

POLICY/GROUP #: _____

CLAIM # _____

SPECIAL INSTRUCTIONS: _____

FINANCIAL ARRANGEMENTS: _____

() MUST HAVE M.D. REFERRAL () AUTHORIZATION FOR FIRST VISIT

() AUTH FOR CONTINUED TREATMENT () DEDUCTIBLE _____

() DEDUCTIBLE MET? _____ () % COVERED PER VISIT _____

() # OF VISITS ALLOWED _____ () MAX VISITS _____ /YEAR/OTHER _____

() LIMITATIONS _____ Y/N PAY FOR SUPPLIE

() ADDITIONAL VISITS _____ () AUTH # _____

() PRESCRIPTION LENGTH _____ X'S PER WK FOR # WKS: _____

() EXPIRATION DATE OF PRESCRIPTION/AUTHORIZATION _____

() DATE OF AUTH: _____ TIME _____ CONTACT PERSON _____

() ADDITIONAL VISITS _____ () AUTH # _____

() PRESCRIPTION LENGTH _____ X'S PER WK FOR # WKS: _____

Hope Therapy

Payment Agreement

I understand Hope Therapy will help bill insurance and deductible/
co-payment is due by cash or check at the time of treatment, unless
prior arraignments have been made.

Paperwork for submittal of insurance claims independently may be
requested. I understand and accept ultimate responsibility for
payment of my account with Hope Therapy.

I have read and understand this policy.

Signature

Date

Cancellation Policy

Cancellations/Make-ups: I understand that if I must cancel a session,
a 24-hour notice is required. I understand that failure to notify Hope
Therapy of a cancellation 24 hours ahead of time will result in the
normal cost of therapy session being charged.

I also understand that I may reschedule any cancelled therapy
sessions.

We recognize and assess individual needs. Excessive cancellations
may cause a loss of reserved time.

I have read and understand this policy.

Signature

Date

Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ Alternative #: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Phone: _____

How did you hear about the program? _____

HEALTH HISTORY

Diagnosis _____ Date of Onset: _____

Please indicate current or past special needs in the following areas:

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

MEDICATIONS (include prescription, over-the-counter; name, dose and frequency) _____

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

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

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

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)
