PATIENT FORM

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

REBECCA DAVENPORT, OTR L
Occupational Therapist

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HOPE THERAPY *is a Premier Accredited Center Member of:*
Professional Association of Therapeutic Horsemanship International (PATH Intl.)

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 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 refused 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, expect 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 inquires.
- 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.

Patient's Consent for Release of Information

I hereby authorize Hope Therapy:

To release information from the records of: _____
(patient's name)

The information is to be release to Hope Therapy for the purpose of developing a Therapeutic Riding Program for the above named patient. The information to be release 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: _____
(Patient, Parent or Guardian)

Please send the indicated material to: ***Hope Therapy***

Patient's Registration and Release Form

Registration

Patient: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

Phone: _____

E-mail: _____

School or Institution presently attending: _____

In case of emergency Contact:_____ Phone: _____
Contact:_____ Phone: _____

Liability Release

_____ *(Patient'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 me/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: its Board of Directors, Instructors, Therapists, Aids, Volunteers and/or Employees for any and all injuries and/or loses I/my son/my daughter/ my ward may sustain while participating in the Hope Therapy Hippotherapy Program.

Date: _____ Signature: _____

(Patient, Parent or Guardian)

Photo Release

I hereby consent to and authorize the use of reproduction by Hope Therapy of any and all photographs and any other media 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: _____

(Patient, Parent or Guardian)

Patient'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 *Hope Therapy* 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.

Patient's Name: _____

Phone: _____ Address:_____

City: _____ State: _____ Zip Code: _____

If 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: _____

(Patient, Parent or Guardian)

Print Name: _____ Phone: _____

Address: _____ City: _____ State: _____

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 Guardian)

Print Name: _____ Phone: _____

Address: _____ City: _____ State: _____

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

Insurance Intake Data

Demographics

Patient Name (First, MI, Last): _____Patient DOB: _____

Responsible Party: _____ Responsible Party DOB: _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other (Specify): _____

Mailing Address: _____Phone: _____

Employer Name/Address: _____

Insurance Policy - Primary

Insurance Co.: _____ Address: _____

Policy ID #: _____ Group #: _____ Phone: _____

Plan Type: _____ (i.e. PPO, POS, HMO, Tricare, Disability, FEP, MC Part A/B, Medicaid, Self-Pay, Grant, Unknown)

Policy Holder's Name: _____ DOB: _____

Insurance Policy - Secondary

Insurance Co.: _____ Address: _____

Policy ID #: _____ Group #: _____ Phone: _____

Plan Type: _____ (i.e. PPO, POS, HMO, Tricare, Disability, FEP, MC Part A/B, Medicaid, Self-Pay, Grant, Unknown)

Policy Holder's Name: _____ DOB: _____

For Office Use Only

Eligibility/Benefits

Effective Date: _____ Deductible: _____ Copay: _____ Coins: _____ OOP Max: _____

Auth Required: ☐ Yes ☐ No # Visits Per Rx/MO/YR: _____

Authorization Info – Initial Treatment

☐ MD Referral Required ☐ Auth Phone #: _____ ☐ Auth #: _____
☐ Rx Length: _____ Tx's Per Week For # Weeks: _____ ☐ Pay For Supplies: ☐ Yes ☐ No
☐ Rx/Auth Expiration Date: _____ Date of Auth: _____ Time: _____ POC: _____
☐ Limitations/Notes: _____

Authorization Info – Continued Treatment

☐ Auth For Continued Tx ☐ Auth # For Continued Tx: _____
☐ Rx Length: _____ Tx's Per Week For # Weeks: _____ ☐ Pay For Supplies: ☐ Yes ☐ No
☐ Rx/Auth Expiration Date: _____ Date of Auth: _____ Time: _____ POC: _____
☐ Limitations/Notes: _____

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Payment Agreement

I understand that Hope Therapy will help bill insurance. 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 a therapy session to be 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*

Patient's Application and Health History

General Information

Patient: _____

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

Address: _____

Phone: _____ Alternate Number: _____

Employer/School: _____

Address: _____

Phone: _____

Parent/Legal Guardian: _____

Address (if different from above): _____

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 requires or equipment needed):

Physical Function *(i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____

_____

_____

_____

_____

Psycho/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?)*

_____

_____

_____

_____

_____

Rebecca K. Davenport, OTL/R
Independent of Hope Therapy, Inc.

1591 Big Branch Rd.
Middleburg, FL 32068
904-887-8451

Patient's Consent and Release for Tele-Health

(Video Conferencing, Telephonic Conferencing, Photographic Mediums)

_____
(Patient First name, MI, Last Name)

I hereby consent to and authorize the use of a Tele-Health medium (e.g. Zoom, Facebook Messenger, FaceTime, Doxy.me, or the like) as a way of secure communications with patients via video conferencing, telephonic conferencing, etc.

Communication mediums will be used for the purpose of continuing occupational therapy services (e.g. continuity-of-care to meet goals initially set and home programs), when patients are unable to be on-site at Hope Therapy due to unforeseen circumstances (e.g. extreme weather, communicable diseases, acts of God).

Signature _____ Date _____
(Patient/Parent/Guardian)