2017

(410) 970-2400

www.unbridledrehab.com

NEW CLIENT PACKET

Thank you for choosing Unbridled Rehabilitation Services, LLC for your pediatric therapy and rehabilitation needs. Please take the time to complete this packet and bring with you on your initial visit.

Equine-assisted Therapy Participant Information Sheet

Thank you for choosing Unbridled Rehabilitation Services. We care about your ***safety***. You can help us to keep yourself and/or your child safe by following a few simple rules:

- Please arrive 15 minutes before your scheduled session to allow sufficient time to be ready for the therapist.
- **Remember to have your child wear the proper riding clothing: ASTM/SEI approved helmet, shoes with a heel and long pants. She/he must always wear an ASTM/SEI approved helmet when mounted**.
- No dangling jewelry. No perfumes, as they attract bees and biting insects.
- Please do not approach or mount the client until the therapist is present and supervising.
- The relationship between the therapist and participant is very important. If your child is having any problems or has special needs, please inform the staff about it. We are here for you.
- Please do not enter stalls or allow your child, siblings, and friends to do so unless supervised by staff.
- Do not put your hands or allow your child, siblings, and friends to put hands through the bars of the stall. Horses are strong and might mistake a finger for a carrot. Please follow our "carroting policy" and place the treat on a dish and slip it under the door.
- You are welcome to bring treats for the horses. Carrots, apples and horse cookies are all welcome; no sugar cubes or candy, please - it hurts their teeth.
- Please remind your child, siblings, and friends not to run or make loud noises in the rider support building, arena and around the horses.
- **Please no flash photography**. The flash may frighten the horses. Staff will be happy to take the horse outside into better lighting if time allows.
- No dogs are allowed in or around the barn and arenas (indoors or outdoors). If you bring your dog and need to keep it on the leash and well away from the horses and riders.
- If you see anything that might be unsafe or dangerous, such as reins that are hanging loose or someone in trouble, PLEASE notify a staff member immediately.
- We welcome your help. If you would like to volunteer, please let us know.

Thank you for your special attention and adherence to these rules.

We look forward to working with you! *Please keep this sheet for your reference*.

Participant Information & Health History

GENERAL INFORMATION

Participant: ____

DOB: ____________ Age: _____ Weight*: _____ Height: _____ Gender: M F * Weight restriction of 190lbs

Employer/School: ______________________________________ Phone: ______________

Parent/Legal Guardian: __________________________________ DOB (Guardian): ____________

Other Caregivers: ____

Caregiver(s) Phone: ______________________________

Referral Source: ____

How did you hear about the program? ______________________________________

HEALTH HISTORY

Diagnosis: ______________________________________ Date of Onset: ______________

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

	Yes	No	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Circulation			
Emotional/Mental Health			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other			

MEDICATIONS *(include prescription, over-the-counter & herbal; name, dose, and frequency)*: ______________________

____

____

____

____

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

PHYSICAL FUNCTION (*e.g., mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*:

____

____

____

____

PSYCHOSOCIAL FUNCTION (*e.g., work/school issues, 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?)*:

____

____

____

____

____

To my knowledge, there is no other information about the applicant that is pertinent to Unbridled Rehab, LLC and/or involvement of horses (mounted therapeutic activities):

____ * ____

Signature of Responsible Party from Page 1 Date **Required Signature of 2nd Parent/Guardian Date**

***2nd signature is required.**

If there is a special circumstance, please contact Katie Roe, Unbridled Rehab manager, to further discuss.

It is understood that photographs/videotapes are routinely made of riders, volunteers, staff members and other participants in the program. Unbridled Rehab is hereby granted permission to make use of such photos/videos in which the rider, family or guests may appear for Unbridled Rehab publications, presentations for public awareness, educational/research or other purposes.

PHOTO RELEASE

I (check one) ___ **DO** ___ **DO NOT** consent to and/or authorize the use and reproduction by Unbridled Rehab of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: ____ Date: ______________________

Participant, Parent or Legal Guardian

Unbridled Rehabilitation Services, LLC 3750A Shady Lane, Glenwood, MD 21738
(410) 970-2400 Fax: (410) 774-4090 info@unbridledrehab.com www.unbridledrehab.com

Therapy Contract

Participant's Name: ____ DOB: ________________

Responsible Party: ____________________________________ Relationship: _______________

Preferred method of contact: **[ ]** Phone call **[ ]** Email **[ ]** Text message

Session Fees:

$175.00 for the initial evaluation (1 hour)
$95.00 per 45-minute visit
$160 per hour visit
$15 Administrative fee*

**Therapy visits that incorporate* hippotherapy as a treatment strategy will be subject to this fee only if the participant elects for visits to be billed through their insurance plan. The administrative fee is assessed in addition to the patient liability per visit (copayment, coinsurance, and/or deductible amounts). *Medicaid recipients are exempt from this fee.*

Pre-payment is requested ***before*** the session begins. Private pay clients can elect to receive a monthly invoice for on-going therapy services. Payment is due and payable upon receipt of monthly invoice. Unbridled Rehabilitation Services, LLC reserves the right to amend this fee structure at any time, with appropriate notice given.

Clients paying through ***insurance*** will be required to pay their co-pay at each scheduled visit, upon arrival. Please be aware that equine-assisted therapies will be run in weekly sessions for 8-week spans, unless otherwise stated by facilitating therapist. Consistency is imperative to achieve the most benefit from equine-assisted intervention; therefore, it is important to secure a time slot for which you are able to ensure consistent attendance each week.

Please plan to arrive for your scheduled session 15 minutes early to allow time for finding helmet, paying fees, and checking in with your therapist prior to start of the visit.

Cancelation Policy:

- Notice of cancellation is required at least **24 hours in advance** by notifying your therapist directly or calling the office at (410) 970-2400. Day-of cancellations will result in a $25 fee.
- In the event of a no-show, no call, we reserve the right to charge a $75 fee (Hardship/medical absenteeism situations may receive special exception).
- An occurrence of 3 consecutive sessions cancelled without appropriate notice will result in forfeiture of the time slot held to allow for Unbridled Rehab to best serve all clients in need of services.

*Please continue the **Therapy Contract** on next page.*

Participant's Name: ____ DOB: ____________________

Medical Information & Approval for Equine-assisted Therapy: Unbridled Rehab reserves the right to request yearly updates of medical histories and to make the final judgment of whether the applicant is medically able to participate in mounted equine activities. In addition, applicants/participants under age 20 with Down's Syndrome will be required to have a negative baseline x-ray prior to initial assessment treatment (evaluation).

Prescription Medicine: All non-emergency prescription medicine should be used before arrival at Unbridled Rehab, Inc. Any persons (staff, volunteer, student/camper and family visitors) needing emergency medication due to a pre-existing condition, should have this noted in file by a physician. In order for Unbridled Rehabilitation Svc, LLC staff to administer emergency medication, release and emergency contact forms must be filled out and on file. Any emergency medication should be carried at all times and include specific directions.

Representation: Applicant and/or Responsible Party warrant and represent that applicant has no disability, impairment or ailment preventing him/her from engaging in active exercise or that will be detrimental to his/her health, safety or physical condition if he/she does so engage or participate. This representation is made by the Applicant and Responsible Party knowing that Unbridled Rehab will rely upon same representation with respect to equine-assisted therapies or other activities offered.

Apparel: **ALL PARTICIPANTS MUST WEAR A SAFETY HELMET THAT MEETS ASTM/SEI STANDARDS & USE SAFETY STIRRUPS**. Both are provided by URS or attending facility. Proper clothing includes long pants and hard-soled shoes preferrably with a heel. Sneakers are not ideal but can be worn if approved by the treating therapist. Unbridled Rehab staff reserves the right to inspect and approve/disapprove of gear and/or require additional gear for safety, weather and other conditions. Please consult with therapist regarding appropriate attire if further clarification is required.

Valuables: Everyone is urged to avoid bringing valuables on the premises. Unbridled Rehabilitation Services, LLC along with its agents or staff, shall not be liable for loss, theft or damage to personal property of applicants, family members or guests.

Liability: Applicant and/or applicant's family and guests using the facilities and equipment, do so at their own risk. Unbridled Rehabilitation Services, LLC shall not be liable for any damages arising from personal injuries or damages sustained in, on or about the premises. Applicant and Responsible Party assume full responsibility for any injuries or damages, and do hereby and forever, release and discharge Unbridled Rehabilitation Services, LLC from any and all claims, demands, damages, rights or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the applicant's, family's, or guests' use or intended use of facilities and/or equipment.

Rules and Regulations: Applicant and Responsible Party agree to abide by all rules and regulations set forth by Unbridled Rehabilitation Services, LLC and the facility at which services are provided. These regulations may be issued or amended, orally or written, at the facility's sole discretion.

Right of Cancellation: Applicant or Responsible Party has the right to cancel this agreement and receive a refund of prepaid sessions within three (3) business days after Unbridled Rehab's receipt of the contract.

______________________________		* ______________________________	
Signature of Responsible Party from Page 1	Date	Required Signature of **2nd Parent/Guardian**	Date

***2nd signature required**.

If there is a special circumstance, please contact Katie Roe at (410) 970-2400, ext. 700 to further discuss.

Therapy Contract – 2nd Page

Billing Information Sheet

Participant's Name: ________________________________ DOB: ______________

Printed names of Parent(s)/Guardian(s): ____

Address: ____

Email address: ____

Home phone: ____________________________ Work/Alt. Phone ____________________

Cell Phone: ____________________________

Do you wish to receive the URS monthly newsletter?
This newsletter includes informational tips and keeps you up-to-date on all of the happenings each month.

(*Check one*) ☐ **Yes** ☐ **No**

Preferred method to receive monthly statement: ☐ **Email** ☐ **Hard mail**

Insurance information:

Insurance company name: ____

Insurance address: ____

Policy number: ____________________________ Group number: ______________________

Eff. date: ______________ Policy holder: ____

DOB: __________________ Address: ____

*A copy of insurance card(s) and driver's license/photo ID will be requested upon receipt of paperwork for initial visit.

Payment Agreement

Participant's Name: ___________________________________ DOB: ______________

Out of pocket fees and co-payments are to be paid in full at the time services are rendered.
Thank you.

Payment Information:

Social Security Number of Responsible Party: _________________________*

*__At least the last four of your SSN is required. Form must be complete.__

I plan that payment will be made by:

_____ Rider _____ Parent _____ Legal Guardian

_____ Organization (____)

Insurance agreement: (*select one*)

[ ] I elect to bill therapy visits to my health insurance plan with the understanding that I am responsible for payment of co-payment, deductibles, and/or services that are not paid in full.

[ ] I will pay the out of pocket fees for service and understand that services will not be billed to my health insurance.

By signing this document, I certify that any service rendered by Unbridled Rehabilitation Services, LLC for the above will be paid by me, the Responsible Party. The difference in cost not covered by medical insurance will be the responsibility of and paid by the Responsible Party. I understand that all services rendered by Unbridled Rehabilitation Services, LLC must be paid in a timely manner. If special circumstances arise, Unbridled Rehab must be informed immediately to ensure we are able to accommodate needs in a fair and reasonable manner at the discretion of URS management.

____
Signature of Responsible Party/Guarantor Date

____
Printed Name of Responsible Party/Guarantor

Confidentiality Policy and Agreement

Unbridled Rehabilitation Services, LLC shall preserve the right of confidentiality for all individuals in its program. Any and all full and part-time staff, independent contractors, temporary employees, volunteers, and others, shall keep confidential all medical, social, referral, personal, and financial information regarding a person and his/her family.

Unbridled Rehab recognizes that a participant or his/her family members may not have legal authority to disseminate information, whether due to age or mental capacity. As a general rule, infants and children under the age of 18 years DO NOT have legal authority to consent to disclosure. Only parents, legal guardians, or others (as defined by the state statute) have this authority. Adults with developmental disabilities are presumed legally competent to give or deny disclosure unless they have been adjudicated incompetent to make this type of health care decision. If a substitute decision-maker has been appointed, Unbridled Rehabilitation Services LLC, and its representatives, must obtain specific and informed written consent from that individual.

The policy extends to all situations involving Unbridled Rehabilitation Services LLC and its clients, whether or not any information was disseminated accidentally or on purpose.

Unbridled Rehabilitation Services, LLC shall not disseminate to its employees or others, knowledge of a person's medical or sensitive information unless there is a risk to others through casual contact and permission has been obtained.

Unbridled Rehabilitation Services, LLC shall reserve the right to use universal precautions for all situations in which staff may be exposed to the blood of a client. Unbridled Rehabilitation Services, LLC shall act under the assumption that all clients may have a blood borne disease. Such actions do not indicate a breach of confidentiality, but rather a general policy for use in all situations in which persons are exposed to another's blood.

Unbridled Rehabilitation Services, LLC shall only disclose information to outside agencies/individuals with the specific written consent of the client/legal representative. In cases of medical emergency due to illness or injury while receiving services rendered by Unbridled Rehabilitation Services, LLC or while on the property of the attending facility, this policy shall recognize to the required Authorization for Emergency Medical Treatment as such required written consent.

Any breach of the above confidentiality policy by staff, volunteers, and other persons will result in:

1) a documented verbal warning;
2) a formal written reprimand;
3) dismissal.

Confidentiality Statement

By signing below, I certify that I understand and will observe the confidentiality policy of Unbridled Rehabilitation Services, LLC.

____________________________________ ____________________________________

Signature Date Witness Signature / URS staff Date

____

Print Name

Consent for Release of Information

I hereby authorize: ____
(outside person or facility – ie pediatrician or other therapist)

to release information from the records of: ____________________________ DOB: __________
(participant's name)

The information is to be released to Unbridled Rehabilitation Services, LLC for the purpose of developing an integrated equine-assisted therapy treatment plan for the above named participant. The information to be released is indicated below:

- ☐ Medical History
- ☐ Physical therapy evaluation, assessment and program plan
- ☐ Occupational therapy evaluation, assessment and program plan
- ☐ Speech therapy evaluation, assessment and program plan
- ☐ Mental health diagnosis and treatment plan
- ☐ Individual Habilitation Plan (IHP)
- ☐ Classroom Individual Education Plan (IEP)
- ☐ Psychosocial evaluation, assessment and program plan
- ☐ Cognitive-behavioral management plan
- ☐ Other: ____

This release is valid for one year and can be revoked, in writing, at my request.

I also hereby consent to provide a **physician's prescription** from the referring physician, documenting the need for and clearance to begin physical, occupational, or speech therapy. If there is be a change in medical status, i.e., hospitalization, surgery, or other medical procedure changing the current therapy goals, I will provide an updated prescription.

Signature: ____ Date: _______________

Print Name: ____

Relation to Participant: ____

Please send materials to:

- ☐ Mailing address: 3750A Shady Lane, Glenwood MD 21738
- ☐ Fax # (410) 774-4090
- ☐ Email : info@unbridledrehab.com

Authorization for Emergency Medical Treatment

Participant Name: ___________________________________ DOB: ____________

Primary Physician Name: ____ Phone # _________________________

Preferred Medical Facility: ____

Allergies to medications: ____

In the event of an emergency, contact:

Name: __________________________________ Relationship: __________________ Phone #: ________________

Alt. Phone #: _____________________________

Name: __________________________________ Relationship: __________________ Phone #: ________________

Alt. Phone #: _____________________________

[Select Consent OR Non-Consent plan below and sign]

CONSENT PLAN: In the event emergency medical aid or treatment is required due to illness or injury while receiving services, I authorize Unbridled Rehabilitation Services, LLC and/or the facility in attendance to:

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

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

Consent Signature: ____ Date: __________________

Client, Parent or Legal Guardian

Printed Name of Above: ____ Phone # ______________________

NON-CONSENT PLAN: I do not give my consent for emergency medical treatment/aid in the case of illness or injury while receiving services from Unbridled Rehabilitation Services, LLC.

___ Parent, legal guardian or caretaker will remain on site at all times during equine assisted activities

___ In the event emergency treatment/aid is required; I wish alternate procedures to take place:

____

____

____

Non-Consent Signature: ____ Date: ________________

Client, Parent or Legal Guardian

Printed Name of Above: ____ Phone # ____________________

Unbridled
Rehabilitation Services

Date: ______________________

Dear Health Care Provider:

Your patient ____
(Participant's name)
is interested in participating in equine assisted activities facilitated by a state licensed therapist.

In order to safely provide this service, our center requests that you complete/update the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities according to the governing bodies of our practices, namely, the American Hippotherapy Association and Professional Association of Therapeutic Horsemanship International. Therefore, when completing this form, please note whether these conditions are present, and to what degree.

Orthopedic

Atlantoaxial Instability - include neurologic symptoms

Coxarthrosis

Cranial Defects

Heterotopic Ossification/Myositis Ossificans

Joint subluxation/dislocation

Osteoporosis

Pathologic Fractures

Spinal Joint Fusion/Fixation

Spinal Joint Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt

Seizure

Spina Bifida/Chiari II Malformation/Tethered Coed/Hydromyelia

Other

Age - under 2 years

Indwelling Catheters/Medical Equipment

Medications - e.g., Photosensitivity

Poor Endurance

Skin Breakdown

Medical/Psychological

Allergies

Animal Abuse

Cardiac Condition

Physical/Sexual/Emotional Abuse

Blood Pressure Control

Dangerous to Self or Others

Exacerbations of Medical Conditions (e.g., RA, MS)

Fire Setting

Hemophilia

Medical Instability

Migraines

PVD

Respiratory Compromise

Recent Surgeries

Substance Abuse

Thought Control Disorders

Weight Control Disorder

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine-assisted activities, please feel free to contact us at the address/phone listed below.

Sincerely,

Unbridled Rehabilitation Services, LLC
(410) 970-2400
info@unbridledrehab.com

Medical History and Physician's Referral

Participant: ______________________________ DOB: __________ Height: _______ Weight: _______

Address: ____

Diagnosis: ____ Date of Onset: __________________

Diagnosis Code: ICD-10 ____________________________________

Past/Prospective Surgeries: ____

Medications: ____

Seizure type: _______________ Controlled: Y N Frequency: _________ Duration: ________ Date of last: _________

Shunt Present: Y N Date of last revision: ____

Special Precautions/Needs: ____

Mobility: Independent Ambulation Y N Assisted Ambulation Y N Wheelchair Y N

Braces/Assistive Devices: ____

Unbridled Rehabilitation Services requires that individuals with Down syndrome be fully examined annually for atlantoaxial instability. Once a negative baseline is established, further X-rays are at the discretion of the parents and physician.

Date of X-rays: ___________ Radiologist: ___________________________________ Results: + -

Neurological symptoms of Atlanto-Axial Instability: ☐ Present ☐ Absent

Please indicate any special needs/concerns:	Yes	No	Comments (if necessary, continue on back)
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies (i.e. asthma, bee sting, dust)			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine-assisted activities and/or therapies. I understand that Unbridled Rehabilitation Services LLC, providing services at the PATH Intl. accredited center, TRRC, Inc., will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to Unbridled Rehabilitation Services for ongoing evaluation to determine eligibility for participation. (**PLEASE INCLUDE PRESCRIPTION FORM for PT/OT/SLP appropriate for the specific type of therapy to be provided)**

Name/Title: ______________________________________ MD DO NP PA Other ______________

Signature: ______________________________________ Date: ________________________

Address: ____

Phone: ______________________________ License/UPIN Number: ________________________