CLIENT CONSENT UPDATE

I have reviewed all forms in the client packet, re-consent to all contract agreements previously signed, and hereby verify that all information remains current for the following forms:

- Consent for Release of Information (*Initial*) _____
- HIPAA Compliance & Confidentiality Policy (*Initial*) _____
- Payment Agreement (*Initial*) _____
- Facility Release Agreement/Behavior Contract (*Initial*) _____
- Hippotherapy Agreement (*if applicable*) (*Initial*) _____
- Attendance Policy (*Initial*) _____

I will update the physician referral, emergency contact information, and all pertinent medical information yearly as required by Unbridled Rehabilitation Services, LLC for continued participation.

_____ _____
Signature Date

PHOTO RELEASE

I (check one) ___ **DO** ___ **DO NOT** consent to and/or authorize the use and reproduction by Unbridled Rehab along with TRRC, Inc. 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

INSURANCE INFO & COMMUNICATION UPDATE

Client Name:_____ Client Date of Birth:_____

Parent(s) Name(s):_____

Phone Numbers: Home:_____ Cell:_____ Office:_____

Address: _____

Has your insurance information changed as of January 1, 2018? ☐ YES ☐ NO

Complete 2018 insurance information to update our records:

Insurance Company: _____ Insurance Phone:_____

Policy Holder's Name:_____ Relationship to Client:_____

Policy Number: _____ Group:_____ Policy Holder's DOB:_____

Communication Authorization: I authorize Unbridled Rehabilitation Services to communicate with me regarding to my child's appointments, plan of care, & financial matters in the following form(s):

Email	☐ YES ☐ NO	Email address:
Text	☐ YES ☐ NO	Mobile #:
Phone	☐ YES ☐ NO	
Mail	☐ YES ☐ NO	

Note: Not all text and email systems are 100% secure

Required Action: NEW PRESCRIPTION AND COPY OF NEW INS CARD IS NEEDED

Parent/Guardian Signature_____ Date:_____

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

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www.unbridledrehab.com

Credit Card Authorization

Name on Card:

Card Type:

Account Number:

Expiration Date (MM/YY):

CVV:

Email address for receipts:

Patient Name:

I agree and authorize Unbridled Rehabilitation Services, LLC to charge the above account for all co-payment, deductible, and co-insurance as dictated by my insurance provider including non-covered services & private/non-insurance related services.

Authorized Signer: **Date**

I have reviewed and understand the cancellation policy upheld by Unbridled Rehabilitation Services, LLC and consent that fees pertaining to missed visits without appropriate notice will be charged to the card above. _____(initial)