Unbridled
Rehabilitation Services

Client Information Packet

GENERAL INFORMATION

Client Name: _____ DOB: _____ Age: _____

Weight: _____ Height:_____ Gender: ☐ M ☐ F

Grade: _____ School: _____

Parent/Guardian (*if under 18*): _____ Parent DOB: _____

Address: _____

Email address: _____

Home phone: _____ Cell Phone: _____

Other Caregivers: _____ Phone: _____

Do you wish to receive the URS monthly newsletter? (*Check one*) ☐ Yes ☐ No
This newsletter includes informational tips and keeps you up-to-date on all of the happenings each month.

Preferred method to receive monthly billing statement: ☐ Email ☐ Paper

Preferred contact for appointment reminders: ☐ Email ☐ Text Message ☐ Call

How did you hear about us?_____

HEALTH HISTORY

Diagnosis: _____Date of Onset:_____

Please indicate any needs/concerns in the following areas:

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

Medications (include dosage and frequency):

_____ _____

_____ _____

_____ _____

Parental statement of Primary Concern (*i.e. goals for therapy*):

_____

_____

_____

INSURANCE INFORMATION

Insurance company name: _____

Insurance address: _____

Policy number: _____ Group number: _____

Eff. date: _____ Policy holder: _____

DOB: _____ SSN (must put at least the last 4 digits): _____

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

FEE-FOR-SERVICE FOR 2018

Self-pay:
$175.00 for the initial evaluation (1 hour)
$130 per 60-minute visit
$100 per 45-minute visit

Additional services fees:
$15 Hippotherapy 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 hippotherapy fee is in addition to the patient liability per visit (copayment, coinsurance, and/or deductible amounts). Medicaid recipients and Self-pay clients are exempt from this fee.

Pre-payment is requested at the start of your visit. Self-pay clients can elect to receive a monthly invoice for on-going therapy services, but are required to maintain an active card on file. Payment is due and payable upon receipt of your monthly invoice. Clients paying through insurance will be required to pay their co-pay at each scheduled visit, upon arrival.

Unbridled Rehabilitation Services, LLC reserves the right to amend this fee structure at any time, with appropriate notice given.

Insurance plan benefits verification (*Staff use only*)**:**

Plan Name:_____ Effective date: _____

Plan/policy year from _____ to_____

Copay: _____ / Co-Insurance: _____

Deductible: Ind._____ (met_____) Family:_____ (met_____)

Out of Pocket Max: Ind._____(met_____) Family:_____(met_____)

# of visits allowed:_____ per calendar/contract year (circle one) Visits used?_____

Authorization Required? ☐ YES ☐ NO Comments:_____

Referral Required: ☐ YES ☐ NO

Date/Time Verified: _____Verified with:_____ Reference#:_____

Guarantor acknowledgement:

I understand the benefits as quoted by my insurance company. Benefits are not a guarantee of payment. All claims are subject to review and medical necessity.

Client/ Guardian's Signature: _____ Date: _____

PAYMENT AGREEMENT (*check one below*)

☐ 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 plan.

By signing below, 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 within 15 days of invoice date to prevent interruption of services. 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

ATTENDANCE POLICY

While we understand that illness and family emergencies do arise, prompt and regular attendance to scheduled therapy visits is critical in order to get the best results for your child.

CANCELLATIONS: Notice of cancellation is required at least 24 hours in advance of scheduled appointment by notifying your therapist directly or calling the office at (410) 970-2400 in order to avoid a fee. Less than 24 hour notice will result in a $50 fee.

NO SHOW: In the event of a no show/ no call occurrence, we reserve the right to and will automatically charge a $75 fee. Individual circumstances can be discussed with your therapist and exceptions may be permitted in extenuating circumstances such as hardship or unexpected medical situations. Please know that URS must enforce these policies in order to protect our therapists and ensure services at URS continue to be available for our clients. An occurrence of 3 sessions missed without appropriate notice will result in forfeiture of the appointment slot held to allow URS to best serve all clients in need of services.

INCLEMENT WEATHER: URS will strive to notify all personnel and clients of closure decisions at least 2 hours prior to scheduled appointment. Our facilities follow school closures within the county it is located (City Ranch – Balt.Co; TRRC – Howard Co; Silverado Stables – Frederick Co; Merkel Farm – PG Co). In order to ensure a safe and effective environment for our clients, URS reserves the right to cancel the equine assisted portion of therapy services if the following conditions occur:

- Temperatures above 100 degrees or wind chill/temperature below 25 degrees.
- Winds exceeding 25 MPH.
- Severe weather forecast (Tornado warning, thunder storms, hazardous driving conditions).

In the event that URS needs to cancel appointments, we will make every effort to schedule a make up if possible within the week.

Acknowledgment (*initial*): _____

HIPPOTHERAPY POLICY

if you choose to include any equine assisted treatment into your therapy plan, please note the following:

URS provides holistic, comprehensive therapy services in multiple settings. Our mission is to meet the needs of our clients and their families in the community and home settings. It is the therapist's responsibility and ethical obligation to determine best fit of services for each individual client. Determination of scheduling (frequency/duration) and level of services is done at time of evaluation. During this visit, you can expect to sit down with your therapist to discuss goals, needs, and participate in the treatment planning process.

If at any time, your therapist deems it is inappropriate to incorporate equine movement into your/your child's therapy plan, this will be clearly communicated and documented. *It is not guaranteed that all services will include equine movement at any given time. This is solely to the therapist's discretion based on what is most therapeutic and beneficial to the client at time of treatment.*

Acknowledgment (*initial*): _____

HIPAA COMPLIANCE / CONFIDENTIALITY

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. A copy of the full disclosure can be found on our website at http://unbridledrehab.com/client-center/forms-and-paperwork.

You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing below, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing below, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The client has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The client has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

This consent was signed by : _____

(Printed name)

_____

Signature of Responsible Party/Guarantor Date

Unbridled Rehabilitation Services, LLC shall reserve the right to use universal precautions for all situations in which staff may be exposed to the blood and/or bodily fluids 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 and/or bodily fluids.

Unbridled Rehabilitation Services, LLC shall only disclose information to outside agencies/individuals with the specific written consent of the client/legal representative (found on page 6). 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.

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize: _____
(outside person or facility – i.e. pediatrician or other therapist)

to release information from the records of: _____ DOB: _____
(client's name)

The information is to be released to Unbridled Rehabilitation Services, LLC for the purpose of developing an integrated therapy treatment plan for the above named client. 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)
- ☐ Individualized Family Service Plan (IFSP)
- ☐ 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 pertinent medical information/paperwork clearly documenting the need for and clearance to begin physical, occupational, or speech therapy in the occurrence of any medical status change i.e., hospitalization, surgery, or other medical procedure.

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____

Please send materials to:

- ☐ Mailing address: P.O. BOX 40, GLENELG, MD 21737
- ☐ Fax : (410) 774-4090
- ☐ Email : info@unbridledrehab.com