Unbridled
Rehabilitation Services

Patient Information Packet

Patient Name	Date of Birth / /	Age	Weight	Height ft in	Gender ☐ M ☐ F
Parent/Guardian (if under 18)	Parent DOB / /	School			Grade
Address	City			State	Zip Code
Email Address	Home Phone ( )		Cell Phone ( )		
Other Caregiver	Caregiver's Phone Number ( )				

Would you like to receive emails from us? ☐ Yes ☐ No

How should we contact you for appointment reminders? ☐ Email ☐ Text ☐ Call (Cell) ☐ Call (Home)

How did you hear about us?

Insurance Information

Insurance Company Name			
Insurance Company Address	City	State	Zip Code
Policy Number	Group Number	Effective Date / /	
Policy Holder	Date of Birth / /	SSN (or last 4 of SSN) – –	

A copy of insurance card(s) and driver's license or other photo ID is required on your initial visit.

Self-pay rates vary by location and type of service. Please, inquire on our website or at the front desk for our current rates. Non-refundable registration fees are charged monthly to help URS cover the cost of reserving the treatment facility and administrative costs associated with running the off-site program. The fee also reserves a time slot for a participant for the duration of the sessions at an off-site treatment location chosen. It **does not** cover therapy sessions themselves and patient will be responsible for co-payment, co-insurance, and/or deductible amounts as outlined in benefits quoted by your insurance plan. Payment is required prior to services being rendered. Registration fees must be paid prior to reserving your appointments. Unbridled Rehabilitation Services, LLC reserves the right to amend its fee structure at any time.

Health History

Diagnosis	Date of Onset
	/ /

Primary Care Physician	Referring Physician

Past/Prospective Surgeries	Up to Date on Vaccinations?
	☐ Yes ☐ No

Medications

Seizure Type	Controlled	Frequency	Duration	Date of Last
	☐ Yes ☐ No			/ /

Shunt Present	Date of Last Revision	Special Precautions/Needs
☐ Yes ☐ No	/ /	

Symptom	Yes	No	Comments: Please describe any needs or concerns
Auditory			
Hearing			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Atlantoaxial Instability Disclosure

Unbridled Rehabilitation Services requires that individuals with Down syndrome be fully examined 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
/ /		☐ Positive ☐ Negative	☐ Present ☐ Absent

Insurance Plan Benefits Verification (For staff use only)

Plan Name				Plan/Policy Year from / / to / /
Copay $	Coinsurance $	# of Visits		Deductible: total Individual $ / Family $
Auth. Required? ☐ Yes ☐ No		Referral Required? ☐ Yes ☐ No		Out of Pocket Max: total Individual $ / Family $
Comments				

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.

Patient/Guardian's Signature:	Date / /

Financial Policy Acknowledgement

I authorize URS 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 agree to pay out of pocket fees for services not covered by my insurance.

URS requires an active credit card on file to be charged monthly for any outstanding balances (payment authorization form is attached). I agree to update URS with current payment information.

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. 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 and to avoid 10% monthly interest charges. Accounts over 90 days past due will be forwarded to credit reporting collections agency. Once the account is forwarded to said agency, a 25% fee will be assessed on any owed balances.

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 **and** calling the office at (410) 970-2400 in order to avoid a cancellation fee.

Less than 24 hour notice or a **no show** will result in automatic billing of cancellation fees as follows:

$75 fee per office visit.
$100 fee per off-site visit (Example: Hippotherapy, Aquatic therapy, group therapy).

If URS cancels appointments for any reason, every effort will be made to reschedule and the cancellation fee will not apply.

Add-On Services Policy

Hippotherapy, Equine assisted therapy, home visits, group therapies, and workshops are offered to each individual patient solely at the treating therapist's discretion based on what is most therapeutic and beneficial to the patient at time of treatment. To have the services available, you must be an established and current patient of Unbridled Rehabilitation Services, LLC and your account must be in good standing. Patients seeking periodic (a la carte services) will not qualify for discounts, promotions, and rates extended to URS regular patients.

Consent to Treat/Liability Waiver

I authorize URS and designated personnel to provide treatment as deemed necessary by my therapist. Patient and Responsible Party represent that patient has no condition that would indicate therapy is contraindicated or inappropriate at this time. This representation is made knowing that URS will rely upon same representation for all therapeutic activities offered. I certify I will disclose any information related to change in status, and will keep medical information on file current. Patients and guests using any URS 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 any URS operating location. Patient 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 patient's, family's or guests' use of intended use of the facilities and/or equipment.

Signature of Responsible Party/Guarantor	**Date** / /
Printed Name of Responsible Party/Guarantor	

HIPAA Compliance/Confidentiality Policy

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.

I authorize the following persons to have access to my record and/or to contact URS on my behalf:

Name/Relationship
Name/Relationship
Name/Relationship
Name/Relationship

Emergency Contact and Authorization

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 receiving off-site services, this policy shall recognize the required Authorization for Emergency Medical Treatment as such required written consent. URS requires separate written consent for outside informants. In case of emergency, URS policy is to call 911 and to initiate CPR until EMS arrives.

In the event of an emergency, contact:

Name	**Relationship**
Phone Number ( )	**Alternate Phone Number** ( )

By signing below, I acknowledge receipt and understanding of the policies above.

Signature of Responsible Party/Guarantor	**Date** / /
Printed Name of Responsible Party/Guarantor	

Consent for Release of Information

I hereby authorize:

Outside Person or Facility e.g. Pediatrician or Other Therapist

to release information from the records of:

Patient's Name	**Date of Birth**
	/ /

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** / /
Printed Name	**Relationship to Patient**

Please send materials to

- ☐ **Mailing Address**: 11419 Cronridge Drive, Suite 9, Owings Mills, MD 21117
- ☐ **Fax**: (410) 774-4090
- ☐ **Email**: info@unbridledrehab.com