Boulder Mountain Therapy
Phone: 480-380-2810
Fax: 480-380-2861
www.bouldermountaintherapy.com

Dear Parents or Guardians,

Thank you for contacting Boulder Mountain Therapy. Our commitment to quality service as therapists includes documentation and following our professional and state mandated guidelines. Please complete the following packet to the best of your ability. In addition, please include a copy of your insurance card(s), front and back, and a copy of your child's prescription if available. Your child will be placed on our waitlist upon returning your completed packet to our facility and a therapist will contact you when therapy services are available.

- ☐ New Patient Registration Form (Front and Back)
- ☐ Copy of Insurance card (Copy of Both Sides)
- ☐ Prescription for Physical, Speech, or Occupational therapy (Duration & Frequency)
- ☐ Liability Release
- ☐ Release of Information
- ☐ Welcome Sheet
- ☐ Hippotherapy clients: Medical Release & Physicians Statement Form
- ☐ Private Insurance and /or DDD Authorization
- ☐ Policies & Procedures
- ☐ Acknowledgement of Notice of Privacy Practice.

Thank You,
Boulder Mountain Therapy

Return packet to:
Boulder Mountain Therapy
844 N. Ellsworth Rd
Mesa, Arizona 85207
or E-mail Bldrmoun@aol.com

Patient Information: **New Patient Registration**

Name ______________________________DOB___________________Age____Gender F / M

Home Phone (______)___________________ Cell Phone (______)________________

Address____Email______________________________

City____________________State_____________Zip______________

Parent/ Guardian Name______________________Phone (______)__________

Referring Physician_________________________Phone (______)___________Fax (____)__________

Insured Person's Information:

Insured Name___________________________________Insured SSN_____________DOB_____________

Address____City________________State______Zip_________

Home Phone (______)_________________Work Phone (______)___________Employer_______________

Primary Insurance Company Name______________________________Phone (______)_______________

Member ID# ____________________________Group #___________________

Secondary Insurance Company Name____________________________Phone (______)_______________

Member ID#_____________________________ Group #______________________________

DDD (Y, N) If yes,

Support Coordinator______________________Phone (_____) _____________Fax (_____) _______________

Is the patient receiving therapy elsewhere? (Y, N) If yes, where? ______________________________

Requested service(s): ☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **Music Therapy** ☐ **Speech Therapy** ☐ **Aquatics** ☐ **Hippotherapy**

Preference (circle):

	Monday	Tuesday	Wednesday	Thursday	Friday
	Am / Pm	Am / Pm	Am / Pm	Am / Pm	Am / Pm
Times:	____________	____________	____________	____________	____________

Assignment of Benefits: I hereby give my consent for treatment. I authorize my licensed/ certified therapist and/ or billing agent to release any medical or incidental information to process this claim for financial benefits. This assignment will remain in effect until revoked by me in writing. I hereby authorize payments of medical benefits be paid directly to Boulder Mountain Therapy for services rendered. A photocopy of this assignment shall be considered as effective and valid as the original. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THESE SERVICES.

Signature of patient, insured, or responsible party____________________________________Date_______________

Client's Name______________________________Primary Language in the home________________________
Social and/ or Education settings client is in:____
Diagnosis:____ Date Diagnosed:________________
Were there any **complications** during pregnancy/labor or delivery?______________________________________

____

At what ages did the client…

Sit Alone?______________________ Walk?__________________________

Crawl?_________________________ Speak?_________________________

What are the **goals** you are hoping to achieve here in therapy/ what is your main concern?___________________

____

Is the client currently taking any **medications**? If yes, please list_______________________________________
Allergies/Restrictions (Food/Meds/Other)?____
Things that **aggravate** the client (loud noises, textures, sounds, etc.)?_______________________________

____

What are the **positive reinforcements** for the client?____
Communication: Verbal Non-verbal Signs

Please check areas where there have been difficulties: (include previous hospitalizations and surgeries)

	Current			**Previous**		
	Yes	No	Comments	Yes	No	Comments
Hearing						
Visual/ Glasses						
Seizures						
Textures						
Speech/ Language						
Cardiac						
Circulation						
Skin						
Balance						
Learning Disabilities						
Cognitive						
Emotional/ Psychological						
Pain						
Orthopedic						
Aggression						
Self Esteem						
Self Injurious Behavior						
Property Destruction						
Feeding						
Interaction with others						
Other						

Current Immunizations: Yes No

Mobility:

Assistive Device? If yes, please list:____

Ambulatory? Yes No

Transfers? Independent Requires prompting Limited Asst. / Supervision Significant Asst.

Other:

Child **resides** with: (Name/ Relationship)____

____

Custodial Type: Both Parents Mother Only Father Only Other:______________________

Who is **authorized** to pick up your child after therapy?____________________________________

Name: (Please print)________________________________ Phone Number: (   )______________________

Liability Release

I understand that horses are unpredictable and even the most docile animal can and may step on, bite, push off balance, stumble, throw, or otherwise injure any person working with or around it. Safety precautions will be exercised by me for my own protection and I agree to abide by the policies and procedures of Boulder Mountain Therapy, as such policies may be amended from time to time. I also agree to exercise proper care and conduct at all times while on or near any horses, including wearing safety helmet and closed toe shoes with heels.

Neither Boulder Mountain Therapy nor any of its officers, instructors, volunteers, participants, employees, agents, or owners of the property where Boulder Mountain Therapy events are conducted shall be held liable for any claims, demands, injuries, or damages, arising out of or in connection with my participation in any Boulder Mountain Therapy event.

I further acknowledge that I will not hold Boulder Mountain Therapy, its officers, instructors, volunteers, participants, employees, agents, or owners of the property, where Boulder Mountain Therapy events are conducted, liable, or responsible for any injury sustained by me while participating in activities at sites where horse therapy classes and related events may be held. I ride and/or participate at my own risk, and agree to take all necessary precautions to prevent all accidents. These precautions include, but are not limited to, the wearing of protective headgear.

I hereby release Boulder Mountain Therapy, its officers, instructors, volunteers, participants, employees, agents, or owners of the property, where lessons, horse shows or other Boulder Mountain Therapy events occur, from all liability for property damage and personal injury to me, I assume the risk of injury which I may sustain arising from approaching, handling, or riding a horse in connection with Boulder Mountain Therapy activities.

This agreement shall apply to any horse or horses being used or maintained upon the grounds where a Boulder Mountain Therapy event is being held, or any person or equipment affiliated with the event.

Furthermore, I assume full responsibility and liability for the conduct and safety of any and all persons I bring onto the property where Boulder Mountain Therapy events are conducted, including minors.

I have read and understand all of the above and waive any claim which may arise against Boulder Mountain Therapy, its officers, instructors, volunteers, employees, agents, or owners of the property where Boulder Mountain Therapy events are conducted.

This agreement is effective upon signing and continues so long as I participate in Boulder Mountain Therapy events.

I agree to pay all costs and attorneys' fees arising from any suit, legal proceedings or threatened proceedings which are or may be brought by me contrary to the terms of this Agreement.

Signature of Rider or Patient:___________________________________Date: ___________________

Signature of Parent/Guardian (if under 18): ____

RISK MANAGEMENT STATEMENTS:

- I understand that I cannot smoke while on the property of Boulder Mountain Therapy. **Y N**
- I understand Boulder Mountain Therapy has designated business hours at which time the staff are present or on the property. **Y N**
- I understand that I must wear an ASTM/SEI approved riding helmet to ride. **Y N**
  I understand that horses are not to be fed anything by hand. Hand feeding encourages biting. **Y N**
- I understand that horses are unpredictable and may kick, bite, or step on me. **Y N**

SIGNATURE: _______________________________________ (Parent or Guardian if under 18)

PHOTO RELEASE:

I hereby consent to and authorize the use and reproduction by Boulder Mountain Therapy of any and all photographs and any other audiovisual materials taken of me/my child/ my ward, for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

SIGNATURE: _______________________________________ (Parent or Guardian if under 18)

Boulder Mountain Therapy
Phone: 480-380-2810
Fax: 480-380-2861
844 N. Ellsworth
Mesa, AZ. 85207

Participants Consent for Release of Information

I hereby authorize: ____
(Person or facility)
To release information from the records of: ____________________DOB:__________
(Participant's name)

The information is to be released to Boulder Mountain Therapy for the purpose of evaluation or ongoing therapy treatment to above address. I have read and completed the information on my own behalf freely, voluntarily and without coercion. This authorization will be valid until I revoke in writing.

The infromation to be realeased is marked below:

[ ] All Medical Records
[ ] Medical Records From: _________ To _________
[ ] Other:____

Signature:____________________________________ Date:_________

Communication Consent

Please list names of other people authorized to receive information about your child's care i.e. grandparent, habworker, babysitter. [ ] Check box for current caregiver that may not be listed.

Name ____________________________ Name________________________
Name ____________________________ Name________________________

Parent/Guardian Signature:______________________ Date:___________

WELCOME

Please read and complete all of this form as thoroughly as possible. Do not hesitate to ask for assistance if you have any questions.

HOURS OF OPERATION
Monday through Friday 9:00 a.m. to 6:00 p.m. and Saturdays by appointment only

PAPER WORK
All forms should be completed and signed prior to the first therapy session**.**

SCHEDULING
All patients are seen by appointment only. A physician's prescription needs to be obtained by the patient prior to the first therapy session (this pertains to PT, OT, and Speech therapy only.) We will periodically ask for updated prescriptions, referrals and/or new release forms.

CANCELLATIONS
There will be a $25 fee for any missed appointment without a 24-hour notice. This is not covered by insurance. If you are not able to make your scheduled appointment, please call us and we will try to reschedule if possible. However, missing three appointment days without 24-hour notice puts the client in jeopardy of losing their treatment space. **Initials____________**

LATE ARRIVALS
In order to maximize your therapy time it is important to arrive on time. Boulder Mountain Therapy reserves the right to discontinue treatment if late arrivals are deemed a problem. **Initials____________**

PAYMENT PPROCEDURES
Payment for service and co-pays are due at the time services are rendered. We are happy to file charges with your insurance company. Any charges that your insurance company does not cover within 45 days or any deductible/co-pay is immediate responsibility of the patient/insured party. Service will be discontinued for any balance that becomes delinquent. We accept cash and checks. **Initials____________**

OBSERVING THERAPIES
We are happy to have families and friends of patients observe treatment sessions as long as it does not distract the patient. Prior approval from the therapist or instructor must be given. In order to keep the integrity of the session, we ask that you do not interrupt or distract the patient during the therapy session.
Initials____________

HORSES
Do not feed any of the horses. Our animals are on special diets and you may interfere with their health. In addition, unsupervised feeding of animals may result in injury. **Initials____________**

PETS
We have a high commitment to safety for our patients and horses, therefore, no pets are allowed on the premises. You may pet our animals at your own risk. **Initials____________**

PARKING
Please park in the designated areas. Do not block gate access areas. If there is no parking available please ask a staff member for direction.

I understand the information in this form and agree to following conditions.

Signature____ Date___________________

Boulder Mountain Therapy
844 N. Ellsworth
Mesa, Arizona 85207
Phone: 480-380-2810
Fax: 480-380-2861
www.bouldermountaintherapy.com

Dear Physician,

Your Patient, ____ is interested in participating in Equine assisted therapy; Hippotherapy. These sessions will be directed by a PT, OT or SLP.

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 contradictions to Hippotherapy. Therefore, when completing this form, please note whether these conditions are present and to what degree.

Orthopedic

Atlantoaxial Instability- include neurological symptoms
Coxa Arthrosis
Cranial Deficits
Heterotopic Ossification/Myositis Ossificans
Joint subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

Neurologic

Hydrocephalus/Shunt
Seizure
Spinal Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

Medical/Psychological

Allergies
Animal Abuse
Physical/Sexual/Emotional abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical condition
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

Other

Age- under 4 years old
Indwelling Catheters
Medications –I.E. Photosensitivity
Poor Endurance
Skin issues

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted therapy, please feel free to contact the center at the address/phone indicated above.

Medical History and Physician's Statement

Participant:________________________________**DOB:**_____________**Height:**_______**Weight:**__________
Address:____
Diagnosis:____ **Date of Onset:**_______________________
Past/ Prospective Surgeries:____
Medications:____
Seizure Type:______________________________**Controlled:** Y N **Date of Last Seizure:**______________
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:____
For those with Down Syndrome: AtlantoDens Interval X-rays Date:________________ Result + -
Neurological Symptoms of AtlanoAxial Instability: ____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	Comments
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional / Psychological			
Pain			
Other			

Physician Statement:
To my knowledge, there is no reason why this person cannot participate in supervised Equine assisted therapy. However, I understand that the PATH center will weigh the medical information above against the existing precautions & contraindications. I concur with a review of this person's abilities / limitations by a licensed credentialed health professional. (I.e. PT, OT, SLP etc.) in the implementations of an effective equestrian program.

Name / Title:__________________________________ **MD, DO, NP, PA other:**_________________________
Signature:____**Date:**_____________________________
Address:____
Phone Number: (_______)________________________________**License /UPIN Number**____________________

PATIENT ACKNOWLEDGMENT

ACKNOWLEDGMENT RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing this form, you acknowledge receipt of the Notice of Privacy Practice of Boulder Mountain therapy. Our Notice of Privacy Practice provides information about how we may use and disclose your protected health information.

I understand that Boulder Mountain Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that BMT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in BMT Notice of Information practices. I understand that I retain the right to revoke t his consent by notifying the practice in writing at any time.

Our Notice of Privacy Practice is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting the Privacy Officer.

If you have questions about our Notice of Privacy Practice, Please let us know.

[ ] I have chosen to waive my right to a copy of this medical practice's Notice of Privacy Practice. I understand a copy of the current notice will be posted in the Reception area and that I have the Option to request a copy at a later date if I so choose.

Signature of patient/Parent, Legal Guardian: ___________________________________Date: __________

INABILITY TO OBTAIN PATIENT ACKNOWLEDGMENT

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained for the following reason:

[ ] Individual refused to sign

[ ] Other: (Please Specify) ____

Patient Name: ______________________________________Date of Birth:__________________

Staff Signature:_____________________________________Date:_________________________

Boulder Mountain Therapy is proud of our unique facility with both Hippotherapy and Aquatics available on site. If you choose for us to provide these different treatment strategies for your child there will be additional costs.

Cancellations: In order to run our program professionally and efficiently, we ask that you be on time and allow 24 hour notice for all cancellations. **Multiple cancellations without 24 hour notice or No shows will risk losing your treatment time slot**, as we have many clients on our waiting list for these treatment strategies.

Appropriate Dress: If your child is not potty trained they will be required to wear a swim diaper in the pool. This ensures that our pool remains sanitary. We ask that your child be ready for Aquatics with a bathing suit, towel, sunscreen, shoes and protective wear as needed. Aquatic therapy & Hippotherapy are dependent on the weather and we ask that you prepare your child for all conditions should inclement weather move our treatment session indoors. Hippotherapy clients should wear closed toe shoes.

Observation: We request that clients only are allowed beyond the lobby area. Parents, family members and siblings are **no longer permitted near the pool or arena area during treatment sessions without permission from the therapist.** This is to protect our client's right to privacy as well as promote safety. If you wish to observe outdoor therapy sessions please consult your Therapist. .

Costs: Aquatic facility fees will be $ 25.00 per month. Our season usually runs from May through Oct. Hippotherapy then begins in November and will extend to April. Facility horse fees are $ 35.00 per visit. If you pay for 5 visits in advance the rate will be $ 30.00 per visit. Checks are made payable to Boulder Mountain Therapy. For your convenience, a mailbox is provided in the lobby where payments can be placed. Please be sure to place payment in an envelope with your child’s name to ensure credit to the appropriate account.

I have reviewed the Aquatic/Hippotherapy policies and procedures and have agreed to abide by the Boulder Mountain Therapy terms.

Parent/ Guardian Signature: **___________________________________Date: ___________ _**