

Therapy Services- RO

Chatsworth

10860 Topanga Canyon Boulevard
Chatsworth, California 91311
818.700.2971 ph
805.309.5234 fx

Newbury Park/Thousand Oaks

401 Ronel Court
Newbury park, California 91320
805.375.9078
805.309.5234 fx

Patient's Application and Health History to be completed by the Patient, or Parent/Legal Guardian

GENERAL INFORMATION

Patient: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____ M F
Address: _____
Phone: (____) _____ Alternative: _____
Email: _____
Employer/School: _____
Address: _____
Phone: (____) _____
Parent/Legal Guardian: _____
Address (if different from above): _____
Phone: _____
Referral Source: _____
Contact numbers: _____
How did you hear about us? _____

HEALTH HISTORY

Diagnosis: _____

Please indicate current or past problems in the following areas:

	Y	N	Comments
Vision			
Hearing			
Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone/Joint			
Muscular			
Thinking/Cognition			
Allergies			
Other			

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Application, Page 2

What medications are you currently taking, including over the counter medications? _____

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

FUNCTION (i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)

SOCIAL (i.e. Work/School including grade completed, leisure interests, relationships - family structure, support systems, companion animals, fears/concerns, etc. . .)

GOALS: (i.e. What would you like to accomplish through therapy?)

SCHEDULE: Please indicate your preferred location, day and time from our open slots (). Also, indicate times you are unavailable.

CHATSWORTH:

- Monday afternoon
- Tuesday morning
- Tuesday afternoon
- Wednesday morning
- Wednesday afternoon
- Thursday morning
- Thursday afternoon
- Friday morning
- Friday afternoon

* Only PT Available

NEWBURY PARK:

- Monday afternoon
- Tuesday morning
- Tuesday afternoon
- Wednesday morning
- Wednesday afternoon
- Thursday morning
- Thursday afternoon
- Friday morning
- Friday afternoon

*Only PT Available

MEDIA/PHOTO RELEASE

I **CONSENT / DO NOT CONSENT** (circle one) to and authorize the use and reproduction by *Therapy Services-RO* of any and all photographs and any other audio-visual materials taken of me/my child for research, promotional material, social media, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

CONSENT FOR CARE AND TREATMENT

I, the undersigned hereby agree and consent for *Therapy Services - RO* to furnish care and treatment considered necessary and proper in treating my condition.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

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Patient's Authorization for Emergency Medical Treatment

Please Print Clearly

Patient's name: _____ Date of Birth: _____ Phone: _____

Address: _____

Diagnosis: _____

Physician's Name: _____ Medical Facility: _____

Physician Address/phone: _____

Health Insurance Co: _____ Policy #: _____

Allergies to medications? _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, and the above cannot be reached, I authorize *therapy services* or *Ride On* to:

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

Consent Plan

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

Date: _____ Consent signature: _____

Patient, Parent or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date: _____ Non-consent Signature: _____

Patient, Parent or Legal Guardian

A COPY OF THE COMPLETED MEDICAL HISTORY SHOULD BE ATTACHED TO THIS FORM.

--- OVER ---

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Participants Release and Hold Harmless Agreement

This Release Limits our Liability. Read it!!!

By signing this form, I acknowledge that equine assisted activities is a dangerous activity which may result in injury to me, my horse, or my equipment. With this knowledge, in consideration of the services of Ride On Therapeutic Horsemanship and Therapy Services – RO (Ride On) and as inducement for the services of Ride On to provide equine assisted activities to me, I hereby waive release, discharge and hold harmless Ride On, its officers, directors, employees and volunteer assistants, their heirs, executors, administrators, successors or assigns, from any and all liability for damages sustained by me, my family, any animal owned or controlled by me, or for any item or personalty under my dominion and control. Without limiting the generality for the above, I hereby waive and release Ride On, its officers and directors, employees and all volunteer assistants for liability based on the active or passive negligence of said persons and entities.

I hereby agree to indemnify and hold harmless Ride On, its officers, directors, employees and all volunteer assistants associated therewith for any claims which may be made against them, including attorney’s fees and costs of suit in any action based upon or arising from my acts or omissions, or the actions of any animal within my control.

This release extends to all claims, whether presently known or unknown. I hereby expressly waive any benefits I may have pursuant to Section 1542 of the California Civil Code relating to the release of unknown claims, which provides:

“A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release which if known by him must have materially affected his settlement with the debtor.”

I acknowledge that I have read the foregoing and understand the contents thereof.

Dated: _____

Dated: _____ (witness)

MINORS MUST HAVE THE FOLLOWING SIGNED BY THEIR PARENTS OR LEGAL GUARDIANS

I, the undersigned, parent or guardian of _____
for and in consideration of our child’s participation at Ride On Therapeutic Horsemanship state that I have read the waiver, release and hold harmless written above and I expressly agree that the terms and conditions of said waiver, release and hold harmless shall apply to and be binding upon me and my minor child or his or her horse may sustain or cause as a result of said participation. I further warrant I have health and accident insurance for said minor.

Dated: _____ (Parent/Legal Guardian)

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Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. **PLEASE REVIEW IT CAREFULLY and KEEP THIS COPY FOR YOUR RECORDS**

Therapy Services – RO is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Therapy Services- RO uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; fundraising and grant writing and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide schedule reminders, be included in statistics for fundraising, or provide other health related benefits that could be of interest to you.

Therapy Services - RO may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, *Therapy Services - RO* policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Therapy Services - RO may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorize by you, when required by law or in emergency circumstances.

Therapy Services - RO will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that *Therapy Services - RO* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Therapy Director at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on *Therapy Services - RO* health information practices or if you have a complaint, please contact:

Therapy Services at RO – Chatsworth
Gloria Hamblin, Program Director
10860 Topanga Canyon Blvd.
Chatsworth, CA 91311
818.700.2971
gloria@rideon.org

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Patient Information Acknowledgment Form

I have read and fully understand *Therapy Services - RO* Notice of Information Practices. I understand that *Therapy Services - RO* may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment, payment or fundraising. 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 *Therapy Services - RO* 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 *Therapy Services - RO* Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying *Therapy Services - RO* in writing at any time.

Patient

Signature of Patient, or Patient's Parent/Guardian if Minor

Date

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Payment Agreement

Patient: _____

Parent/Guardian: _____

Address: _____

Email: _____ **Phone:** _____

I understand that Therapy services cost, on average, \$120 per treatment. I intend to assure payment to Therapy Services at Ride On in the following manner:

Required Information

E-check – Checking Savings

Account Number: _____

Routing Number: _____

OR

Credit Card – Master Card / Visa / Amex / Discover

Name on card: _____

Number: _____

Expiration: _____ Security Code: _____ Billing Zip code: _____

___ I intend to submit for reimbursement from my medical insurance and will need receipts/superbills. I understand that I am responsible to verify insurance coverage/potential exclusions of coverage with my insurance company directly.

I understand that there is a cost involved in getting staff and horses prepared for each treatment, and realize that I may be charged a \$25 fee if I do not show for an appointment and do not call with adequate notice. Exceptions are made for extenuating circumstances, as discussed with the program director or treating therapist. I will notify the therapist or Program Director of any changes in the above information so appropriate arrangements can be made for payment.

Signature – patient or parent/guardian

date

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PRESCRIPTION

Patient: _____ Date: _____

Address: _____

Phone: _____ Date of Birth: _____

Diagnosis: _____ Date of Onset: _____

PHYSICAL THERAPY

- physical therapy evaluation
- physical therapy treatment
- other _____

OCCUPATIONAL THERAPY

- occupational therapy evaluation
- occupational therapy treatment
- other _____

SPEECH/LANGUAGE THERAPY

- speech/language therapy evaluation
- speech/language therapy treatment
- other _____

Frequency: _____ Duration: ___ 1 year _____

___ other _____

Precautions/Comments: _____

PLEASE PRINT

Name/Title: _____ MD DO NP PA other _____

Signature: _____ Date: _____

Address _____

City: _____ Zip: _____ Phone: (____) _____

Fax: (____) _____ License/ UPIN Number: _____

Email: _____

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Ride On



Enrollment Form

Information on annual family income is required to determine client eligibility for certain services funded by the City of Los Angeles through the Community Development Block Grant Program. Please fill out the form below and find the row with the number of persons in your family and circle the family income range appropriate for you. We treat this information

First Name		Last Name	
Address	Apt. #	City	Zip Code
Phone # ()	Birthdate ____/____/____	Age: _____	
		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	

Please Check All That Apply

Disability <input type="checkbox"/> Disabled Adult (16 and Over) <input type="checkbox"/> Disabled Child (15 and Under) <input type="checkbox"/> None	Education Level <input type="checkbox"/> 0 - 8th Grade _____ <input type="checkbox"/> 9 - 12th Grade _____ <input type="checkbox"/> 2 or 4 Year College Degree <input type="checkbox"/> High School Grad / GED	Customer Family Type <input type="checkbox"/> Single Adult <input type="checkbox"/> Two Adults No Children <input type="checkbox"/> Single Parent <input type="checkbox"/> Two Parent Family
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Race (please check one of the following categories)

Ethnicity (check One)

<input type="checkbox"/> American Indian Or Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> White (not Hispanic or Latino)	<input type="checkbox"/> Asian AND White <input type="checkbox"/> Black or African American AND White <input type="checkbox"/> American Indian AND Black/African American <input type="checkbox"/> Balance/Other	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic /Latino
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2018 CDBG Income Guidelines (Circle one)

Family Size	B: Income	C: Income	D: Income	E: Income
1 Person	\$0 - \$23,700	\$23,701 - \$39,450	\$39,451 - \$63,100	\$63,101 +
2 Persons	\$0 - \$27,050	\$27,051 - \$45,050	\$45,051 - \$72,100	\$72,101 +
3 Persons	\$0 - \$30,450	\$30,451 - \$50,700	\$50,701 - \$81,100	\$81,101 +
4 Persons	\$0 - \$33,800	\$33,801 - \$56,300	\$56,301 - \$90,100	\$90,101 +
5 Persons	\$0 - \$36,550	\$36,551 - \$60,850	\$60,851 - \$97,350	\$97,351 +
6 Persons	\$0 - \$39,250	\$39,251 - \$65,350	\$65,351 - \$104,550	\$104,551 +
7 Persons	\$0 - \$41,950	\$41,951 - \$69,850	\$69,851 - \$111,750	\$111,751 +
8 Persons	\$0 - \$44,650	\$44,651 - \$74,350	\$74,351 - \$118,950	\$118,951 +

Ride On gives over 1,700 Scholarship lessons and treatments per year. The income and ethnicity information above is critical when we pursue funding sources, seek support for scholarships and to determine eligibility for public services funded by the City of Los Angeles. I certify that the information on this form is accurate and complete.

Signature (parent if needed) _____ Patient Name: _____ Date: _____

Address: _____

Ride On Staff: _____ Signature: _____ Date: _____