PATIENT FORM

4246 W Highway 318
Citra, FL 32113
(904) 540-5853

CARA GILISON, OTD, OTR/L, AHCB
Occupational Therapist and Board Certified in Hippotherapy

PATIENTS RIGHTS

A patient's bill of rights is established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, his/her family, and our treatment team. The following rights of each of our patients will be upheld:

- To be fully informed prior to or at the time services are initiated of these rights and of all of the regulations and procedures governing treatment services at this facility.
- To be fully informed at the time of initial service of the services available at this facility and of the fee schedule for such services.
- To be fully informed by the treatment professional involved as to the nature and scope of the treatment services to be provided.
- To refused treatment at any time.

To be assured confidential treatment of personal, medical, and treatment records and to approve or refuse their release to any individual outside of this facility, expect as required by law of third-party payment contract.

- To be treated with consideration, respect and full recognition of dignity.
- To be assured that the personnel who provide treatment are licensed and qualified through education and experience, to carry out the treatment services for which they are responsible.
- To receive prompt response to all reasonable inquires.
- To be afforded the opportunity to participate in the planning of his/her treatment wherever possible.
- To be provided information about his/her handicapping condition so that he/she can participate more fully in the Treatment Plan.
- To have the right to voice concerns about the Treatment Plan without fear of restraint or discrimination.

Therapy on Hooves is committed to providing the best treatment program possible for each of our individual patients. We are pleased to have the opportunity to work with you and/or your family.

Patient's Consent for Release of Information

I hereby authorize Therapy on Hooves:

To release information from the records of: ________________________________
(patient's name)

The information is to be release to Therapy on Hooves for the purpose of developing a occupational therapy plan of care for the above patient. The information to be release is marked below:

___ Medical History

___ Physical Therapy evaluation, assessment and program plan

___ Occupational Therapy evaluation, assessment and program plan

___ Speech Therapy evaluation, assessment and program plan

___ Classroom Individual Education Plan (I.E.P)

___ Other: ____

Date: ______________ Signature: ____________________________________
(Patient, Parent or Guardian)

Please send the indicated material to: ***Therapy on Hooves***

Patient's Registration and Release Form

Registration

Patient: ______________________________ DOB: ____________ Age: ______

Address: ____

City: __________________ State: _____ Zip Code: ________________

Home Phone: ________________ Work Phone: ________________

Parent/Legal Guardian: ____

Address (if different from above): ____

Phone: ____

E-mail: ____

School or Institution presently attending: ___________________________________

In case of emergency Contact:______________________ Phone: ______________

Contact:______________________ Phone: ______________

Liability Release

_____________________________ *(Patient's Name)* would like to participate in the Therapy on Hooves Hippotherapy Program. I acknowledge the risks and potential for risks of horseback riding. However, I feel that the possible benefits to me/my son/my daughter/ my ward are greater than the risk assumed.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators waive and release forever all claims for damages against Therapy on Hooves Occupational Therapy: its Therapists, Aids, Volunteers and/or Employees for any and all injuries and/or loses I/my son/my daughter/ my ward may sustain while participating in the Therapy on Hooves Hippotherapy Program.

Date: ______________ Signature: ____

(Patient, Parent or Guardian)

Photo Release

I hereby consent to and authorize the use of reproduction by Hope Therapy of any and all photographs and any other media materials taken of me/my son/ my daughter/my ward for promotional printed material, educational activities of any other use for the benefit of the program.

Date: ______________ Signature: ____

(Patient, Parent or Guardian)

Patient’s Authorization for Emergency Medical Treatment Form

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, I authorize *Therapy on Hooves 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.

Patient’s Name: ______________________________

Phone: ____________________ Address:___________________________

City: __________________ State: _____ Zip Code: ____________________

If I cannot be reached Contact:____________________ Phone: _____________

Contact:____________________ Phone: _____________

Physician’s Name: ____

Preferred Medical Facility: ____

Health Insurance Co: _____________________ Policy #: __________________

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 below is unable to be reached.

Date: _________ Consent Signature: __________________________________

(Patient, Parent or Guardian)

Print Name: ___________________________________ Phone: _____________

Address: ______________________ City: __________________ State: _____

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.

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Date: _______ Non-Consent Signature: ________________________________

(Patient, Parent or Guardian)

Print Name: ___________________________________ Phone: _____________

Address: ______________________ City: __________________ State: _____

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

Payment Agreement

Payment is due by cash or check at the time of occupational therapy evaluation and treatment, unless prior arraignments have been made.

I understand and accept ultimate responsibility for payment of my account with Therapy on Hooves.

I have read and understand this policy.

____ ________________

Signature *Date*

Cancellation Policy

Cancellations/Make-ups: I understand that if I must cancel a session, a 24-hour notice is required. I understand that failure to notify Therapy on Hooves of a cancellation 24 hours ahead of time will result in the normal cost of a therapy session to be charged.

I also understand that I may reschedule any cancelled therapy sessions. We recognize and assess individual needs. Excessive cancellations may cause a loss of reserved time.

I have read and understand this policy.

____ ________________

Signature *Date*

Patient's Application and Health History

General Information

Patient: ____

DOB: __________ Age: _____ Height: ______ Weight: ________ Gender: M F

Address: ____

Phone: _______________________ Alternate Number: _______________________

Employer/School: ____

Address: ____

Phone: ____

Parent/Legal Guardian: ____

Address (if different from above): ____

Phone: ____

How did you hear about the program? ____

Health History

Diagnosis: ____________________________________ Date of Onset: ____________

Please indicate current or past special needs in the following areas:

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

Medications *(include prescription, over-the-counter, name, dose, and frequency)*

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Describe your abilities/difficulties in the following areas

(include assistance requires or equipment needed):

Physical Function *(i.e. mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

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Psycho/Function *(i.e. work/school including grade completed, leisure interests, relationships – family structure, support systems, companion animals, fears, concerns, etc.)*

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Goals *(i.e. why are you applying for participation? What would you like to accomplish?)*

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Cara R Gilison, OTD, OTR/L, AHCB
Therapy on Hooves, PLLC

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Patient's Consent and Release for Tele-Health

(Video Conferencing, Telephonic Conferencing, Photographic Mediums)

____
(Patient First name, MI, Last Name)

I hereby consent to and authorize the use of a Tele-Health medium (e.g. Zoom, Facebook Messenger, FaceTime, Doxy.me, or the like) as a way of secure communications with patients via video conferencing, telephonic conferencing, etc

Communication mediums will be used for the purpose of continuing occupational therapy services (e.g. continuity-of-care to meet goals initially set and home programs), when patients are unable to be on-site at Therapy on Hooves due to unforeseen circumstances (e.g. extreme weather, communicable diseases, acts of God)

Signature ____ *Date* ______________________
(Patient/Parent/Guardian