2020

Address: 3141 SW 118 Terrace, Davie, Florida 33330
Office: (754) 779-7888 **Fax: (954) 414-8363** **Email:** *Info@BitByBitTherapy.org*

Dear New Applicant,

Welcome to our program!

If you have not done so, please call (754) 779-7888 and speak with the *Intake Coordinator* to begin the enrollment process.

We will collect your information over the phone before we will give you an appointment. (*Please also have your Medicaid information on hand if applicable*.) Please also be prepared to sign up for our easy autopay option at this time and have your credit card or bank information ready.

AUTOPAY OPTION: With our *free auto pay option*, you will be emailed a receipt for payment immediately. We accept all major credit cards. We can also auto debit from your bank account. . With auto-pay you can avoid late fees and it can be stopped at any time. This is our preferred method of payment.

We are a *community supported organization* that relies on the sponsorship of families, local businesses, and generous community members. If you feel that you would qualify for a scholarship from Bit-By-Bit, please visit our website for an application. Bit-By-Bit may provide partial or full scholarships depending on our budget constraints, a rider's financial need, and/or extenuating circumstances.

- **Please attach a copy of the front and back of your child's insurance card.**
- If you are going to be participating in our therapy program, a prescription is required from your doctor.
- Only a physician clearance is required for our recreational therapeutic riding/adaptive riding program. (No prescription)
- Please review our pricing policy and bring payment for entire month during initial visit.
- **You can hand in your application at your initial visit or fax/email it to us.**
- You may visit our website for MapQuest access for directions to our facility: ***www.bitbybittherapy.org***

Barn Address: 3141 SW 118 Terrace, Davie, FL 33330

Directions from the West: From I-595 get off at Flamingo Rd. and head South. Turn Left on SW 26 St. Turn Right on SW 121 Ave/ Peaceful Ridge Rd. and Turn left onto SW 32nd Drive & then veer left onto cul-de-sac SW 118th Terrace and we are at end of street.
Directions from the East: If you are coming from the east, you may exit I-595 at Hiatus Rd and head south. Turn right at SW 26th St. Turn Left on SW 121 Ave/ Peaceful Ridge Rd. and turn left onto SW 32nd Drive & then veer left onto cul-de-sac SW 118th Terrace and we are at end of street.

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Billing Policy and Procedures:

- Pre-payment ***in full*** for the entire month is to be made at the beginning of every month. You may pay in advance by check, money order, or credit card (no cash please). We also offer an **autopay option** that our staff can sign you up for. With autopay, you will receive a receipt immediately via email upon payment withdrawal. Please speak with Intake Coordinator about signing up for autopay. Payment has to be received no later than 15th of each month in order to avoid a $15 late payment fee.
- We offer ***standing*** **monthly appointments**; therefore, the following applies: We do not offer partial sessions, each participant is required to pay in advance for no less than one session per week for the entire month.

Cancellation Policy:

- We do not refund money for cancellations. We do offer make-ups for cancellations provided we were given more than a 24-hour notice. If we are not given 24-hour notice or there is no notification of cancellation, a $15 "No-Show" Fee may be charged, and the session will be forfeit. If a participant "No Shows" 2 or more times, they may be discharged. In the case rain, we can perform therapy in our treatment room or barn. In severe weather, we offer a make-up session, not a refund. We will always notify you by phone if your session will be cancelled or delayed. It may be raining in one area, but sunny a few blocks away. **Your session will run as scheduled unless you receive a call from us. If you do not come to your session, you will be charged a $15 fee.**

Therapy/ Hippotherapy / Equine Assisted Therapies & Activities:

Medicaid (and related subnetworks)	**Are accepted plus an additional flat "Barn Fee" of $82 per month for 1 session/week/ 4 sessions a month.** **This fee is the responsibility of the family.** Please pay the Intake Coordinator prior to your initial session. **Some therapy services and private pay clients do not require a barn fee.*
Private Physical/ Occupational/ and Speech Therapy Services:	May be paid privately at the rate of **$85.00 per half hour session**. Private insurance is **not accepted, but** monthly statements will be provided so that **you may submit your own insurance claims**. *(Please check with your individual insurance carrier, as all/ partial therapy services may be covered and reimbursed directly to you.)*

Therapeutic Recreational/ Adaptive Riding Program: **Not reimbursable by insurance.**

Therapeutic Riding Programs:	Price:	Description: (**Physician clearance is required.)**
Private Lessons	$50.00	30 minutes of private riding instruction
Group Lessons (2 – 4 riders)	$50.00	45-60 minutes of total instruction: Activities depend on independence level of the group. Time will be spent on riding, tacking, and aftercare as required.

"Horses For Heroes" Veteran Rehabilitation Program is offered completely free of charge to our disabled veterans.

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Barn Rules: KEEP THIS FOR YOUR RECORDS

- Please arrive at least 10 minutes early for your appointment and have your child prepared for their riding session (bathroom duties complete). ☺
- All riders **must** **wear appropriate clothing** for equine activities every time:
  - ➢ **Wear closed toe shoes with socks:** Boots or sneakers only! No Sandals, flip-flops, crocs, or open toes are to be worn by anyone, riding or not, as you may get your toes stepped on by a horse. Parents, THIS INCLUDES YOU TOO!
  - ➢ Wear long pants: Jeans or material pants are okay. (No shorts or capri pants that end midcalf). The rider's legs may become chafed against the leather of the saddle if not protected by long pants.
  - ➢ Wear Sunglasses and Sunblock: It is hot in Florida, so protect all exposed areas.
  - ➢ Helmets: If you own an approved equestrian riding helmet, please bring it. If not, we have many that are available to be borrowed for your session. *Bike helmets are not acceptable, as they do not afford adequate protection.* For riders with special needs that may require an alternative helmet, speak with your therapist or instructor for specific approval and fitting.
- Please be careful to fully hydrate prior to riding. Water is the best way to hydrate BEFORE and DURING your ride. Please drink plenty of water before arriving and ***bring bottled water with you for each session.***
- Please immediately notify us of any health or behavioral changes you may have noticed in your child at the beginning of your session. We like to stay informed!
- **Please Do Not Feed the Horses or any other animals. All animals bite and can kick.**
- Supervise all children/siblings while on the premises, as there are natural hazards on site. All children must be supervised in the bathroom area. Our fences are ELECTRIFIED, and while we do turn them off during session, the wires may hurt an inadequately supervised child. No climbing on fences or gates ever!
- You may not take video or photos of any child other than your own.
- **You may not walk around the barn without the direct supervision your instructor.**
- Please do not climb on fences or the mounting block while lessons are running. Please seat yourself adequately far from the mounting block to avoid potential accidents and distractions.
- Please remember that you are a GUEST at our facility. Please respect our property, staff, volunteers, animals and other guests. We are a place of HEALING therefore any loud, rude, obnoxious, or otherwise inappropriate behavior will be reason to be invited to leave the premises immediately. We insist on keeping our program in a positive atmosphere, so if you have personal issues or complaints, make sure you only discuss them in **private** with staff or wait until you can reach your therapist or instructor by phone. Privacy & Courtesy are important!
- Always call if you have any questions regarding the above policies.

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Authorization for Emergency Medical Treatment Form

Name___________________________________ DOB: ___/___/_____ Phone: (___) - ______-_______
Address: ______________________________________City________________St _______ Zip ________
Physician: ____
Preferred Medical Facility: _______________________Health Insurance Company: ____________
Insurance ID # ________________________Allergies to any Medications: ___Yes ___No
If yes, which medications: ____
Medications Currently taking: ____

In Case of Emergency, contact:

Name: __________________________________Relationship: __________ Phone: ___________
Name: __________________________________Relationship: __________ Phone: ___________

In the event that 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 Bit-By-Bit to:

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

(Recommended) 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 emergency contact person(s) above are unable to be reached.

Date: __/__/____ Consent Signature: ____
Client, Parent or Legal Guardian, ***signed***

OR:

(Not Recommended) 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.

- Parent or legal guardian **will remain on site** at all times during equine assisted activities
- In the circumstance that I am not on site in violation of Bit-By-Bit policy, I will be financially responsible for any emergency treatment. In the event emergency treatment/aid is required, I wish the following procedure(s) to take place:

____

____

Date: ____/____/_____ Non-Consent Signature: ____
Client, Parent or Legal Guardian, ***signed***

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Participant's Application and Health History

Participant Name:

Date of Birth: / / Age: Height: Weight: Gender: M F

Race/Ethnicity (circle): White Asian African American Hispanic Other________________

Address:

Phone:

Email Address: Employer/School:

Parent or Legal Guardian Name:

Address if different from Participant: Phone:

Referral Source: Referral 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			Please list

MANDATORY: Other THERAPY SERVICES your child receives presently: (please complete)

☐ Speech Therapy for how many minutes______ / how many times per week_________ / What facility___________________

☐ Physical Therapy for how many minutes______ / how many times per week_________ / What facility___________________

☐ Occupational Therapy for how many minutes______ / how many times per week_________ / What facility_______________

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Medications (*include prescription and over-the-counter)*

Name	Dose	Frequency

Please describe your abilities/difficulties in the following areas. (Include assistance required or equipment needed)

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

____

____

____

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

____

____

____

GOALS (i.e. Why are you applying for participation? What would you like to accomplish?)

____

____

____

Signature ______________________________ **Date:** ____________________

PHOTO RELEASE:

X I DO ***(suggested default)*** **☐ I DO NOT (you may check)**

consent to and authorize the use and reproduction by Bit-By-Bit , Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Date: ______________ Consent Signature: ______________________________

Client, Parent or Legal Guardian

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STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

As an Out-Patient client you have the right to:

1. Be given information about your rights and responsibilities for receiving therapy services
2. Receive a timely response from the therapy company regarding your request for therapy services.
3. Be given information of the therapy company's policies, procedures, and charges for services.
4. Choose your therapy providers
5. Be given appropriate and professional quality therapy services without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.
6. Be treated with courtesy and respect by all who provide therapy services to you.
7. Be free from physical and mental abuse and or neglect.
8. Be given proper identification by name and title of everyone who provides therapy services to you.
9. Be given necessary information so you will be able to give informed consent for your treatment prior to the start of any treatment.
10. Be given complete and current information concerning your diagnosis, treatment, alternatives, risks and prognosis as required by your physician's legal duty to disclose, in terms and language you can reasonably be expected to understand.
11. A plan of care that will be developed to meet your unique health care needs.
12. Participate in the development of your health care plan.
13. Be given an assessment and update of your developed health care plan.
14. Be given data and privacy and confidentiality.
15. Review your clinical record at your request with prior notice and physician's order.
16. BE given information regarding anticipated transfer of your therapy care to another health care provider and /or termination of therapy services to you.
17. Voice grievance with and/or suggest change in therapy services and/or therapist without being threatened, restrained, and/or discriminated against.
18. Refuse treatment within the confines of the law.
19. Be given information concerning the consequences of your refusing treatment.

As an Out-Patient client you have the responsibility to:

1. Give accurate and complete health information concerning your past illnesses, hospitalization, medications, allergies, and other pertinent items.
2. Assist in developing and maintaining a safe environment
3. Inform the therapy company when you will not be able to keep a therapy visit.
4. Participate in the development and update of your health care plan.
5. Adhere to your developed/updated health care plan.
6. Request further information concerning anything you do not understand.
7. Give information regarding concerns and problems you have to the therapist/therapy company.

STATE OF FLORIDA: Department of Health and Rehabilitative Services

TO REPORT ABUSE, NEGLECT, OR EXPOLOITATION, PLEASE CALL TOLL FREE 1-800-96-ABUSE. THIS SERVICE IS AVAILABLE 24 HOURS A DAY,7 DAYS A WEEK.

I understand my Bill of Rights and have received a copy of it.

Signature of client/client representative Date

Signature of Therapist Date

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CONSENT/RELEASE/BILL OF RIGHTS

PATIENT NAME: ______________________________________

CONSENT TO RECEIVE SERVICES	I hereby authorize Bit-By-Bit, Inc. to render appropriate health care to patient named above. I recognize and agree that I have the right to refuse treatment or terminate services by notifying Bit-By-Bit, Inc. In addition, Bit-By-Bit, Inc. may terminate services by notifying me of termination and the reason.
AUTHORIZATION FOR EMERGENCY MEDICAL SERVICES	At any such time that Bit-By-Bit, Inc. is on assignment, and in the event of any medical emergency, I authorize Bit-By-Bit, Inc. to provide or obtain such medical treatment as deemed advisable under the circumstances, and I agree to assume sole responsibility for all charges for such treatment
RELEASE OF MEDICAL RECORDS	I hereby consent and I request that copies, if necessary of my prior medical records be delivered to Bit-By-Bit, Inc. to establish or continue my home health care treatment plan. I hereby authorize Bit-By-Bit, Inc. to release copies of my medical records, or reports or such portions or summaries thereof as may be relevant, to other health care providers, facilities, or regulatory or accrediting bodies for the purpose of continuing and coordinating my plan of treatment and for quality assurance, survey and accreditation purposes.
MEDICAID/PAYMENT AUTHORIZATION	As a Medicaid patient, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made to Bit-By-Bit, Inc. on my behalf. I also certify that I will provide all necessary paperwork/documentation/notifications to Bit-By-Bit immediately if there is a change in my Medicaid status. **I also certify that I will provide Bit-By-Bit, Inc with all necessary paperwork so that this provider can effectively bill Medicaid and/or my primary insurance company in a timely manner. I certify that failure to do so on my part, I will be personally financially accountable and liable for private pay therapy rates for the services rendered to me and/or my family member/ child.**
STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES	I certify that I have read, received a copy, and understand the Statement of Patient Rights & Responsibilities, which has been explained to me orally by a representative of Bit-By-Bit, Inc.
PATIENT'S SIGNATURE	NOTE: This form must be signed by the patient of Bit-By-Bit, Inc unless the patient is a minor, incompetent or physically incapable of signing. I have read and fully understand the content of this multi-purpose admission form, and hereby agree to and authorize the foregoing provisions. As used in this document, the terms, "I", "me", and "my", refer to and include, in addition to the undersigned, the patient named above and others for whom the undersigned has assumed responsibility in engaging Bit-By-Bit, Inc. to provide services to the patient.

______________________________ ______________________________
PATIENT SIGNATURE AUTHORIZED REPRESENTATIVE OF PATIENT

______________________________ ______________________________
WITNESS PRINT REPRESENTATIVE NAME

______________________________ ______________________________
DATE RELATIONSHIP TO PATIENT

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Equine Professional Release

KNOW ALL MEN by these PRESENTS, that

____ (*Write participant name*) who resides at

____(*write address*) (hereinafter referred to as "participant"), desires to engage in and hereby does engage in the services of Bit-By-Bit, Inc., and all of its, EMPLOYEES, Trainers, therapists, instructors, volunteers, board of directors, independent contractors, animals, and others (hereinafter referred to as "EQUINE PROFESSIONAL"), LOCATED AT **:** 3141 SW 118th Terrace, Davie, Florida 33330 to instruct/provide services for the participant in recreational riding, riding lessons, therapeutic riding / adaptive riding lessons, camp, hippotherapy, physical, occupational, and/or speech therapy, medical therapy related services, equine care and management, equine assisted therapy or activities, horse shows, trail riding, Pony Scouts, horse training, parades, workshops, scouting programs, parties, fundraisers , educational classes or workshops, public events, any and all independent contractor and/or volunteer activities, experiences, and duties, transportation and any other farm sponsored, charitable activity or equine activity.

FOR AND IN CONSIDERATION OF THE ABOVE SERVICES, Participant hereby does and forever and finally release, remise, acquit, satisfy and forever discharge Bit-By-Bit, Inc., and all of its, actions, cause and causes of actions, debts, dues, suit, sums of money, bonds, billings, contracts, controversies, agreement, promises, damages, variances, judgments, executions, claims, and demands whatsoever, including, but not limited to attorney's fees and disbursements, in law or in equity, which may arise or might in the future arise or hereinafter may arise for or against the Equine Professional for the services as stated above. This document is meant to be a **full and complete release from all and any liability** and release against any claims based on negligence, actions or inactions of the above named parties, and any claim that may arise from instructing the participant on how to properly ride, manage and care for horses and other animals, and all program activities, medical treatments, therapeutic activities, and/or animal related activities. I hereby release the EQUINE PROFESSIONAL(S) from any and all liability from any injury or damage that may occur from participation in the inherently risky equine activities that may or may not be the result of either simple and gross negligence, and by signing this agreement acknowledge the possible risks and dangers that could result from participation in equine activities, whether caused by the equine sponsor's negligence or the inherent risks of equine activities. This release is given freely and voluntarily by the participant and is meant to remain in existence throughout the duration of any instruction, medical treatment, charitable, independent contractor, volunteer, or equine related activity. **Photo release:** I also consent to **or** (check *only if applies*- O do not consent to) and authorize the use and reproduction by Bit-By-Bit, Inc. of any and all photographs and any other audio/visual materials taken of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

WARNING:

Under Florida law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

Dated this ________________ day of _____________________________, _______________

Participant Signature __________________________________ Phone ___________________________________

Legal Guardian Signature (required if < 18 years old)____

Emergency Phone Number:____

Complete Address ____

****Email Address****: ____

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FOR DOCTOR!! Attach with next page for physician signatures.

Date: ___________________

Dear Health Care Provider:

Your patient, ____ is interested in participating in **supervised equine activities**.
(Participant's name)
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 contraindications to equine activities.**

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

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

Neurologic
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II malformation/Tethered Cord Hydromyelia

Other
Age – under 4 years
Indwelling Catheters/Medical Equipment
Medications – i.e. photosensitivity
Poor Endurance
Skin Breakdown

Medical/Psychological
Allergies
Animal Abuse
Cardiac Condition
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions, (i.e. RA, MS)
Fire Settings
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorder

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

Sincerely,
Susan March, *RPT*
Executive Director of Bit-By-Bit

2020*

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Participant's Medical History & Physician's Statement (for DOCTOR!)

Participant: ________________________________ DOB: ____/_____/____ Height ______ Weight _____
Address: ____
Phone:(________) ___________________________ Client Email address: _____________________________________
Diagnosis: ______________________________**ICD-10 Code**: _______________________ 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: ____
Independent Ambulation ☐ Y ☐ N Braces/ Assistive Devices ☐ Y ☐ N Wheelchair ☐ Y ☐ N
For those with Down Syndrome: AtlantoDens Interval X-rays, date: ________________ results + --
Neurologic Symptoms of AtlantoAxial Instability: ____

Please indicate current or past special needs 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			
Pain			
Other			

Doctor Prescription:

(Required for Medical Therapy Services)

Date: ________ / ________ / ________

Patient: ____
ICD-10 Code: ____

RX: PLEASE CHECK SERVICE(S) PRESCRIBED:
- ☐ **Physical therapy**
- ☐ **Occupational therapy**
- ☐ **Speech therapy**

Evaluation and treatment.

Signature:

____
(Physician handwritten signature only)

MANDATORY: Physician Medicaid Provider ID # :

____

Given the above diagnosis and medical information, this person is not medically precluded from participation in equine assisted activities. I understand that the PATH center will weigh the medical information given against the existing precautions and contraindications. Therefore, I refer this person to the PATH center for ongoing evaluation to determine eligibility for participation.

Doctor Name Printed:____**MD DO NP Other** ______________
Signature:__________________________________ **Date:** _______________ **License/UPIN Number**________________________
Office Phone: (________ **)**_________________________________ **Office Fax :_(**________**)**____________________________
Office Address: ____