THERAPYWORKS NW

Physical, Occupational & Speech Therapy

www.therapyworksnw.com • 503-663-0481 • Fax 503-663-0480 • 7927 S.E. Orient Drive, Gresham, OR 97080

Patient Name:_____Date of Birth:_____

Parent/Guardian Name (1):_____

Address _____City_____State_____Zip_____

Home Phone #:_____Cell:_____Work:_____

Parent/Guardian Name (2):_____

Address _____City_____State_____Zip_____

Home Phone #:_____Cell:_____Work:_____

Parent/Guardian Email(s): (1)_____(2)_____

Emergency Contact _____Phone:_____

Emergency Contact Relationship to Patient: _____

Patient's diagnosis/diagnoses (if known): _____

_____

Primary Care Physician:_____ Office Name:_____

Patient Status: Foster Child **[ ]** Adopted **[ ]** Bio **[ ]**

Case Worker Name (if Foster):_____ Phone:_____

Primary Insurance Company Name_____

Subscriber Name _____Date of Birth_____

Policy/ID #:_____Group Number:_____

Secondary Insurance Company Name_____

Subscriber Name _____Date of Birth_____

Policy/ID #:_____Group Number:_____

Assignment and Release:

I give consent for TherapyWorks NW to evaluate and treat myself or the above named child to whom I am a parent or legal guardian. I also assign directly to TherapyWorks NW, or Bobbi Culter, any insurance benefit that would be otherwise payable to me for services rendered. *I understand that I may be financially responsible for all charges whether or not paid by insurance*. I understand that a lack of notification of any insurance changes can and often will result in services not being covered, and therefore I may be solely financially responsible for the full cost of services, even for previous dates of service. I hereby authorize TherapyWorks NW to release all information necessary to secure the payment of benefits, and do authorize the use of this signature on all insurance submissions. I also hereby authorize TherapyWorks NW to release all information necessary to report to a referring physician of the above named patient. I acknowledge that any other sharing of my medical information may only be done with my separate signed consent.

_____ _____ _____

Parent or Legal Guardian Signature | Parent or Legal Guardian Name | Date

BACKGROUND INFORMATION

Child's Name: _____ Sex: M / F Age: _____ Grade/Level: _____
School Attended:_____ Teacher's Name:_____
Main Concerns:_____
_____
_____
What would you like to accomplish through therapy?_____
_____
_____
_____

History
Ethnicity/Ethnicities: _____ Languages spoken in home: _____
Age(s) and gender of sibling(s): _____
_____
Complications, illness/ infections/stress during pregnancy? Y / N (describe): _____
Complications during labor and delivery? Y / N (describe): _____
Forceps / Vacuum / C-section? Y / N Birth Order _____ Birth Weight _____
Premature / Postmature / Full Term ? (circle one) Apgar score at 1 min. _____ 5 min. _____
Breast Fed? Y / N How Long? _____ Strong Suck? Y / N Spit up frequently? Y / N
Problems with Feeding / Respiration / Sleeping ?(circle) (describe): _____
Irritable / Happy / Quiet baby? (circle) Arch back and head when upset? Y / N

Developmental Milestones: Please note approximate age at which he/she did the following:
Sat_____ Belly Crawled_____ Crawled_____ Cruised_____ Walked _____Said first words _____
Talked_____ Toilet trained (bladder) _____ (bowels) _____ Undressed self _____
Dressed self _____ Managed snaps, zippers, buttons _____Tied shoes _____ Started preschool_____
Ear Infections? Y / N (How many, what ages?) _____
Preferred hand: L / R ? Age established? _____

Allergies? Y / N _____
Seizures? Y / N _____
Injuries? Y / N _____
Hospitalizations? Y / N _____
Glasses? Y / N (condition) _____
Medications Y / N _____

Other precautions or concerns:_____
_____

PARTICIPANTS RELEASE AND HOLD HARMLESS AGREEMENT

By signing this form, I acknowledge that therapeutic and pleasure horse riding has the possibility of being a dangerous activity which may result in injury. With this knowledge, in consideration for the services of Bobbi Culter P.T. and/or any person associated with the business TherapyWorks NW, and as inducement for the services of Bobbi Culter P.T. and/or any person associated with the business Therapyworks NW to provide therapeutic horse riding and /or physical therapy and or occupational therapy on horseback for me or my child to whom I am parent or legal guardian, I hereby waive, release, discharge and hold harmless Bobbi Culter and/or the business TherapyWorks NW for any and all liability for damages sustained by me, or by my other family members accompanying me to the therapy site, or for any item or person under my dominion and control. This same waiver, release, discharge and hold harmless statement applies to Bobbi Culter P.T. and the business Therapyworks NW to include its officers, directors, employees and volunteer assistants, their heirs, executors, administrators, successors or assigns. Without limiting the generality of the above, I hereby waive and release TherapyWorks NW, its officers and directors 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 Bobbi Culter P.T. and TherapyWorks NW, its officers, directors and all volunteer assistants associated therewith for any claim 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 involved.

I _____, the undersigned parent or legal guardian of _____ (Child's Name) for and in consideration of my child's participation at TherapyWorks NW for hippotherapy services 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 as a result of said participation. I further warrant that I have health insurance for said minor.

_____	_____
Print Name	City, State
_____	_____
Signature	Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

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 TherapyWorks NW to:

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

Patient's Name:_____ DOB: _____
Address:_____
In the event that I cannot be reached:
Emergency Contact 1: _____ Phone:_____
Relationship to Patient: _____
Emergency Contact 2: _____ Phone:_____
Relationship to Patient: _____
Physician's Name: _____
Health Insurance Co. _____Policy/Member #:_____

Consent or Non-Consent to Emergency Medical Treatment (mark one option)
Option A: [ ] I do give consent for emergency medical treatment/aid in the case of illness or injury. This Authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life-saving" by the physician.
Signature: _____ Date: _____
Parent or Guardian

This provision will only be invoked if the person below is unable to be reached:
Name: _____ Relationship to patient: _____ Phone:_____

Option B: [ ] I do not give consent for emergency medical treatment/aid in the case of illness or injury. In the event of an emergency, I wish the following to take place:
_____
_____

Signature: _____ Date: _____
Parent or Guardian

Photo Release (mark one option) **[ ]** I consent to and authorize OR **[ ]** I do not consent to and do not authorize the use and reproduction by TherapyWorks NW of any and all photographs and any other audio-visual materials taken of me or my child for promotional material, educational actives, exhibitions or for any other use for the benefit of the therapy program.
Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

Patient Name

Parent/Guardian Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify)

_____
_____
_____
_____

APPROVED PICK UP/DROP OFF LIST

Please list below any individuals who are ***NOT*** allowed to pick up and/or drop off your child from their therapy appointments:

Name (First and Last)	Relationship to Patient:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note: If your child will be dropped off or picked up from their appointments by someone who does not usually provide transportation, you must notify us ahead of time to provide the name and phone number of this person. Otherwise, we may require a telephone confirmation from primary parent/ guardian of their identity and expected presence before we will release the patient.

_____	_____	_____
Parent or Legal Guardian Signature	*Parent or Legal Guardian Name*	*Date*

24 HOUR CANCELLATION AND NO SHOW POLICY

Regular attendance in therapy is crucial to your child's developmental outcome and missing multiple appointments can hinder your child's growth in therapy. Given the complexity of scheduling, the time our therapists put in to prepare for each individual child, and the patients on our waitlist waiting for services, we require as much regular attendance as possible. As of August 3rd, 2020 the following updates to our cancel and no show policy will take effect:

TherapyWorks NW requires a 24 hour notification if your child will have to miss an appointment. Failure to give us a call, text, or email within 24 hours of your appointment will result in a **$35 fee**. This fee must be paid prior to returning to therapy.

TherapyWorks NW requests that you call to cancel when your child has had a fever, diarrhea, or vomiting within the last 24 hours.

Should your child wake up ill on the day of their appointment, please call to notify us. We will waive the cancellation fee in the event of illness ***IF*** you call by 8:30 am the morning of the appointment. **We will also use discretion on a case-by-case basis to determine whether a fee should be waived for other reasons.** However, recurring cancellations for any reason (including illness) may result in removal from our permanent schedule and your child may be put on our on-call list for fill in appointments each week.

Other important notices:

Over 15 minutes late: Please call to notify us when you will be late to your appointment. If you are over 15 minutes late, individual therapist discretion will be used to determine whether your child will still be seen, or whether you will be charged the no show fee and not be seen that day. A late arrival of over 15 minutes without a call will result in an automatic no show fee and no treatment will be done.

Repeated Cancellations and No Shows: Continued missed appointments without a sufficient reason and/or without sufficient notification will lead to your child being discharged from therapy. We understand that there are times when sometimes families may need to take a break from therapy. In these cases, we can temporarily take your child off of our permanent schedule. Patients will always be welcome to return when regular attendance becomes possible again.

In the case of a late arrival that we have not been notified about, we will take the following steps:

1. Wait 5-10 minutes after appointment start time for the patient to show up.
2. A staff member will call the patient's primary parent or guardian.
3. If there is no answer, a staff member will leave a voicemail.

Agreement Statement:

I, the parent or guardian of _____, do agree to abide by the above stated policy.
Child Name

_____ _____ _____

Printed Parent/Guardian Name *Parent/Guardian Signature* *Date*