



Physical Therapy~Occupational Therapy
Speech Therapy~Music Therapy

Boulder Mountain Therapy

2414 N. Trenton

Mesa, Arizona 85207

Phone: 602-321-1698

Fax: 480-984-0411

e-mail: BldrMoun@aol.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 (Copies of Current IEP &/ or Evaluation)
- Welcome Sheet
- Hippotherapy clients: Medical Release & Physicians Statement Form
- URF (State Contact)

Thank You,

Boulder Mountain Therapy Staff

Boulder Mountain Therapy

C/O Jann Goodman

2414 N. Trenton

Mesa, Arizona 85207

Patient Information:

New Patient Registration

Name _____ SSN _____ DOB _____

Age _____ Gender F / M Home Phone (_____) Work Phone (_____)

Address _____

City _____ State _____ Zip _____ Marital Status _____

Parent/ Guardian Name _____ Phone (_____)

Referring Physician _____ Phone (_____)

Primary Care Physician _____ Phone (_____)

Insured Person's Information:

Insured Name _____ Insured SSN _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) Work Phone (_____) Employer _____

Primary Insurance Company Name _____ Phone (_____)

Policy/ Group # _____ Case Manager/ Contact _____

Secondary Insurance Company Name _____ Phone (_____)

Policy/ Group # _____ Case Manager/ Contact _____

Support Coordinator _____ Phone (_____)

Medical Information:

Diagnosis _____ Date of onset _____

Is the injury related to an employment accident? (Y , N) MVA _____ Other _____

Is the injury related to an auto accident? (Y , N) If yes, do you have an attorney representing you? (Y , N)

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

Requested service(s): Physical Therapy Occupational Therapy Music Therapy Speech Therapy

Aquatics Hippotherapy Therapeutic Riding

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 I revoked by me in writing. I herby authorize payments of medical benefits be paid directly to Boulder Mountain Therapy Specialists for services rendered. A photocopy of this assignment shall be considered as effective and valid as the original. I UNDERSTAND THATI AM FINACIALLY 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 (Food/Meds/Other)? _____

Things that **aggravate** the client (loud noises, textures, sounds, etc.)? _____

What are the **positive reinforcers** for the client? _____

Communication: Verbal Non-verbal Signs

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

	Current		Comments	Previous		Comments
	Yes	No		Yes	No	
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						

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 The Therapy Zone/Horses Help, 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 The Therapy Zone/ Horses Help nor any of its officers, instructors, volunteers, participants, employees, agents, or owners of the property where The Therapy Zone/ Horses Help 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 Therapy Zone/ Horses Help event.

I further acknowledge that I will not hold The Therapy Zone/ Horses Help, its officers, instructors, volunteers, participants, employees, agents, or owners of the property, where The Therapy Zone 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 The Therapy Zone/ Horses Help, its officers, instructors, volunteers, participants, employees, agents, or owners of the property, where lessons, horse shows or other Therapy Zone/ Horses Help 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 The Therapy Zone/ Horses Help activities.

This agreement shall apply to any horse or horses being used or maintained upon the grounds where a Therapy Zone/ Horses Help 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 The Therapy Zone/ Horses Help events are conducted, including minors.

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

This agreement is effective upon signing and continues so long as I participate in The Therapy Zone/ Horses Help 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 The Therapy Zone/ Horses Help Y N
- I understand Therapy Zone/ Horses Help 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 and Nipping 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 The Therapy Zone 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
2414 N. Trenton
Mesa, Arizona 85207
Phone: 602-321-1698
Fax: 480-984-0411
e-mail: BldrMoun@aol.com

Participants Consent for Release of Information

I hereby authorize: _____
(person or facility)

To release information from the records of: _____ DOB: _____
(participants name)

The information is to be released to Boulder Mountain Therapy specialists for the purpose of evaluation or ongoing therapy treatment.

The information to be released 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
- Psychosocial Individual Education Plan (I.E.P.)
- Cognitive- Behavioral management Plan
- Other: _____

Signature: _____ Date: _____

Please send response information to:

Boulder Mountain Therapy Zone
C/O Jann Goodman
2414 N. Trenton
Mesa, Arizona 85207

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 8:00 a.m. to 12:00 p.m.

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. The Therapy Zone 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, any deductible or co-pay is immediate responsibility of the patient/insured party. Service will be discounted 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 _____



Rehabilitation and Learning Center

PO Box 50219
Mesa, Arizona 85208-0219
Tel: 480-380-2810 / Fax: 480-380-2861
E-mail: Thetherapyzone@aol.com

Dear Physician,

Your Patient, _____ is interested in participating in supervised equestrian activities.

In order to safely provide this service our center requests that you complete/ updated the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contradictions to therapeutic horseback riding. 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

Other

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

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

Thank you very much for your assistance. If you have any questions or concerns regarding this patient's participation in therapeutic equine activities, 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 equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precaution and contraindications. I concur with a review of this person's abilities / limitations by a licensed /credentialed health professional. (E.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name / Title: _____ **MD, Do, NP, PA other:** _____
Signature: _____ **Date:** _____
Address: _____
Phone Number: () **License /UPIN Number** _____