



2523 14 3/4 Avenue  
 Rice Lake WI 54868  
 (715) 859-6670

## PATIENT APPLICATION AND HEALTH HISTORY

To be completed by the participant, or parent/legal guardian

### GENERAL INFORMATION

Participant Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ M F  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Alternative Phone: \_\_\_\_\_  
 Employer/School: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Supervisor/Teacher: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Parent/Legal Guardian: \_\_\_\_\_  
 Address (if different from above): \_\_\_\_\_

Referral Source: \_\_\_\_\_

How did you hear about the program? \_\_\_\_\_

### HEALTH HISTORY

Please indicate current or past problems in the following areas:

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Vision	___	___	_____
Hearing	___	___	_____
Sensation	___	___	_____
Communication	___	___	_____
Heart	___	___	_____
Breathing	___	___	_____
Digestion	___	___	_____
Elimination	___	___	_____
Circulation	___	___	_____
Emotional	___	___	_____
Behavioral	___	___	_____
Pain	___	___	_____
Bone/Joint	___	___	_____
Muscular	___	___	_____
Thinking/Cognition	___	___	_____
Allergies	___	___	_____

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)

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**SOCIAL** (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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## RELEASE FORMS

### PHOTO RELEASE

I consent to and authorize the use and reproduction by Nature's Edge Therapy Center, Inc. of any and all photographs and any other audio-visual materials taken of the patient, patient family or friends during treatment sessions, for promotional material, educational activities, exhibition, or for any other use for the benefit of the program.

\_\_\_\_\_  
Signature of Client, Parent or Legal Guardian

\_\_\_\_\_  
Date

### REGISTRATION AND RELEASE FORM

I, \_\_\_\_\_ (Parent/Guardian's Name) would like to participate in Nature's Edge Therapy Center, Inc.'s therapy program. I acknowledge the risks and the potential for risks of the programs use of horses and other animals. However, I feel that the possible benefits are greater than the risks assumed. I hereby forever release, discharge, and hold free and harmless, for myself, my heirs, and assigns, executors or administrators, all claims for damages against Nature's Edge Therapy Center, Inc., it's instructors, therapists, aides, volunteers and /or employees, and the Lundeen Ranch of any and all injuries and /or loses the client or clients family may sustain while participating in the therapy program.

\_\_\_\_\_  
Signature of Client, Parent or Legal Guardian

\_\_\_\_\_  
Date



# CASE HISTORY FORM

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Mothers' Name: \_\_\_\_\_ Fathers' Name: \_\_\_\_\_

Diagnosis: Medical \_\_\_\_\_  
Treatment \_\_\_\_\_

Referring Doctor Name: \_\_\_\_\_ U-Pin #: \_\_\_\_\_

Clinic Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Primary Insurance Company Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_  
Deductible/Co-pay: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Onset Date: \_\_\_\_\_  
Insurance Company Form or Requirements: \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes please explain: \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Policy Holder Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_  
Deductible/Co-pay: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Onset Date: \_\_\_\_\_  
Insurance Company Form or Requirements: \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes please explain: \_\_\_\_\_

## Wisconsin Medicaid Information:

MA Number: \_\_\_\_\_



## Consent for Therapy and Therapy Pay Status/Letter

Date: \_\_\_\_\_

To: \_\_\_\_\_

Therapy services are available to all patients at Nature's Edge and provided by qualified speech, physical and occupational therapists. Therapy services have been prescribed by Dr. \_\_\_\_\_ for the following treatment: \_\_\_\_\_. A review of the patient's medical history and condition by the physician and therapist indicates that the services are medically reasonable and necessary. The item checked below is an explanation of the current payment source for the therapy services provided. Your signature is required for approval so that we may go ahead with the therapy as soon as possible.

\_\_\_\_ MEDICAL ASSISTANCE (Wisconsin)

The cost of the therapy services will be billed to the Title XIX (Wisconsin Medical Assistance) program as long as eligibility requirements are met. If coverage is pending and does not become effective or if eligibility changes, you are responsible for payment for services rendered at the rate stated below in Private Pay / Private Insurance section.

\_\_\_\_ PRIVATE PAY / PRIVATE INSURANCE

Based upon determination, effective \_\_\_\_\_, the prescribed therapy services are not covered by Medicaid. Patient will be seen \_\_\_\_\_ times per week for therapy. The amount of time in therapy may vary. All charges will appear on your monthly statement. **Any amounts not paid by insurance remain the patient's responsibility. Co-pays, deductibles and co-insurance are due at the time of service.**

CHARGE FOR EVALUATION: \_\_\_\_\_ CHARGE FOR THERAPY SESSION \_\_\_\_\_

Please feel free to contact the therapist or the business office if you need further explanation before signing this approval. Return a signed copy in the enclosed envelope. Please keep a copy for your records.

Your signature indicates that (1) you agree with the provisions of the payment source as described above, (2) you authorize payment of any insurance benefits directly to Nature's Edge Therapy Center, (3) you authorize medical information to be released to Nature's Edge Therapy Center and for Nature's Edge Therapy Center to release information for professional and claims purposes. Upon written notice to the administrative office you can inspect or receive copies of the medical record upon payment of expenses. (4) You authorize rehabilitative therapy to be provided in the presence of others who may not be directly involved in the provision of treatment. The patient's case is confidential and will not be discussed openly.

**NOTE: Nature's Edge Therapy Center will bill appropriate payers. If payment is not received in full within 60 days by third party payers it remains the patient's responsibility in full at this time. After 30 days interest will incur in the amount of 1.8% per month.**

PLEASE NOTE, CANCELLATION WITHOUT A 24 HOUR NOTICE WILL RESULT IN A \$30.00 CHARGE PER VISIT. THREE CANCELLATIONS WITHOUT NOTICE MAY RESULT IN A TERMINATION OF THERAPY SERVICES.

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

Authorized \_\_\_\_\_

Not Authorized \_\_\_\_\_

Patient or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Log: \_\_\_\_\_

# PARTICIPANT INTEREST SURVEY

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date: \_\_\_\_\_ Grade Level: \_\_\_\_\_

School you attend: \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

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What do you hope to accomplish during this program? \_\_\_\_\_

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What activities are you most interested in participating in? \_\_\_\_\_

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What is your favorite animal? \_\_\_\_\_

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What, if any, previous experiences have you had working with large and/or small animals?

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What, if any, previous experiences have you had with gardening and/or landscaping projects?

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