Nature's Edge
THERAPY CENTER INC

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

NEW PATIENT CHECKLIST

Thank you for your interest in therapy services at Nature's Edge Therapy Center, Inc. For your convenience, we've put together the following list of the items we need before we can accept any patient for treatment. If you have questions about any of these items or about completing the attached forms, please contact the Business Office at Nature's Edge Therapy Center, Inc., by phone or email, and we will be happy to help you.

- ❑ Patient History and Participation Agreement, fully completed and signed
- ❑ Signed Release Forms
- ❑ Signed Hippotherapy Exclusion Agreement
- ❑ Authorization for Emergency Medical Treatment, completed and signed
- ❑ Completed Case History Form
- ❑ Consent for Therapy, Release of Information, and Therapy Pay Status Letter, fully completed and signed
- ❑ Completed Patient Interest Survey
- ❑ Doctor's prescription for the therapy services desired, stated in these terms (as applicable):
  - "Occupational Therapy Evaluation and Treatment as indicated"
  - "Speech Therapy Evaluation and Treatment as indicated"
  - "Physical Therapy Evaluation and Treatment as indicated"

  The prescription must also include a **diagnosis**, as well as a **diagnostic code**. A formal and inclusive diagnosis list is extremely helpful.
- ❑ Current IEP (Individual Education Plan), if applicable, or other state or county care plan developed for the patient
- ❑ Medical records from past therapists, if available
- ❑ Completed Application for Discounted Services or Application for Grant for Diane's House Services, if applicable
- ❑ Copy of insurance card

Nature's Edge THERAPY CENTER INC.

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

PATIENT HISTORY AND PARTICIPATION AGREEMENT

To be completed by the patient or parent/legal guardian

GENERAL INFORMATION

Patient's Last Name: _____ First Name: _____
Date of Birth: _____ Age ___ Height: _____ Weight: _____ M F
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Alternative Phone: _____

Employer/School: _____
Address: _____
City: _____ State: _____ Zip: _____
Supervisor/Teacher: _____ Phone: _____

Parent/Legal Guardian: _____
Address (if different from above): _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Alternative Phone: _____
Secure Email Address: _____

Referral Source: _____

How did you hear about Nature's Edge? _____
_____
_____

THERAPY HISTORY

Is the patient <u>currently</u> receiving *any* therapy services (physical, occupational, and/or speech therapy services) at any location (school, private clinic, county, etc.)? □ Yes □ No
If "yes," please tell us where and who the therapist is: _____
_____

Has the patient had therapy (physical, occupational, and/or speech therapy) <u>in the past</u>? □ Yes □ No
If "yes," please tell us where, when, and who the therapist(s) was: _____
_____
_____
_____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

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

What medications is the patient currently taking, including over-the-counter medications? _____

_____

_____

Describe the patient's abilities/difficulties in the following areas, including assistance required or equipment needed:

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

_____

_____

_____

_____

_____

_____

SOCIAL (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/the patient applying for treatment? What would you/the patient like to accomplish?)

_____
_____
_____
_____
_____
_____

PARTICIPATION AGREEMENT

I, _____ (Patient's/Parent's/Guardian's Name), hereby agree that I will schedule and attend prescribed therapy sessions with the patient (or assign a consistent caregiver to do so) and will be responsible for implementing the home program and strategies as recommended by the therapist(s) in order to facilitate progress toward the patient's goals. I understand that Physical, Occupational, and Speech Therapy are medically prescribed treatments and that failure to comply with the therapist's recommendations implies to the referring physician an unwillingness to participate in therapy recommendations.

a) In order for your therapist to provide the best possible treatment for the patient, it needs to be understood that patient/caregiver cooperation and participation with a "home program," "carryover program," or "recommendations" be followed and charted/documented in the home setting in order to determine measurable benefits of the program or the need to modify a treatment strategy. **It is understood that should recommendations not be completed three consecutive treatment times in a row, the patient will be discharged from therapy.**

b) In order for your therapist to provide the best possible treatment for the patient, it also needs to be understood that the patient/caregiver must cooperate with Nature's Edge in scheduling and attending prescribed, regular treatment sessions. **Frequent cancellations, tardiness, gaps in treatment visits, and no-shows will result in monetary charges and/or discharge from therapy.** (Please refer to CONSENT FOR THERAPY, RELEASE OF INFORMATION, AND THERAPY PAY STATUS LETTER for more information.)

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Nature's Edge THERAPY CENTER INC

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

RELEASE FORMS

REGISTRATION AND GENERAL RELEASE FORM

I, _____ (Patient's/Parent's/Guardian's Name), hereby apply for participation in Nature's Edge Therapy Center, Inc.'s therapy program. I acknowledge the risks and the potential for risks of the program's 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., its therapists, instructors, aides, volunteers, and /or employees, and the Payne Ranch, of any and all injuries and /or losses the patient, patient's family, or guests may sustain while participating in the therapy program.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

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 audiovisual materials taken of the patient, patient's family, or guests while in treatment for use in promotional materials, educational activities, exhibitions, or for any other use for the benefit of Nature's Edge Therapy Center, Inc.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

HELMET RELEASE

I, _____ (Patient's/Parent's/Guardian's Name), hereby give permission for Nature's Edge Therapy Center, Inc.'s therapists to forego the use of a helmet for _____ (Patient's Name) when necessary to prevent any distractions from therapy goals. I acknowledge the risks and the potential for risks of not using the helmet when on a horse. 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., its therapists, instructors, aides, volunteers, and /or employees, and the Payne Ranch, of any and all injuries and /or losses the patient may sustain while not wearing a helmet.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

DAMAGE AGREEMENT

I, _____ (Patient's/ Parent's/Guardian's Name), hereby agree that I will be responsible for seeing that any children, guests, or animals brought by me on the premises of Nature's Edge Therapy Center, Inc. are properly supervised at all times while on such premises. I further agree that I will be liable for any damage to the property of Nature's Edge Therapy Center, Inc. or the Payne family, while on the premises of Nature's Edge Therapy Center, Inc., or in the Payne home, and/or for any loss of use of such property resulting from any such damage, caused by my negligence or that of any child, guest, or animal brought on such premises by me. I further agree to pay for any necessary repairs or to reimburse Nature's Edge Therapy Center, Inc. and/or the Payne family for the reasonable cost of repair, replacement, and/or loss of use of such property pending repair or replacement.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Nature's Edge THERAPY CENTER INC

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

HIPPOTHERAPY EXCLUSION AGREEMENT

I understand that not all insurance providers will grant payment towards a facility that "uses the horse as a treatment tool" (otherwise known as hippotherapy). If your insurance provider does not cover hippotherapy and you, the patient or parent/guardian of the patient, still wish to utilize equine movement to facilitate therapeutic benefit, an "OT/ST/PT Hippotherapy Charge" will be charged directly to the patient, and other treatments (non-equine based) will be charged to the insurance company.

I do understand and agree to the above statement. Please sign and date below.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

I do not agree to the above statement. (In this case, the use of the horse as a treatment tool (mounted) will not be utilized for therapeutic purposes.) Please sign and date below.

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Nature's Edge THERAPY CENTER INC

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event of an emergency, contact:

Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Consent Plan
In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services from, or while being on the property of, Nature's Edge Therapy Center, Inc., and the above cannot be reached, I authorize Nature's Edge Therapy Center, Inc. to:

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

This authorization includes X-rays, surgery, hospitalization, medication, and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ Date: _____
Patient, Parent, or Legal Guardian

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 from, or while being the property of, Nature's Edge Therapy Center, Inc. In the event emergency treatment aid is required, I wish the following procedures to take place:

_____
_____
_____
_____

Non-Consent Signature: _____ Date: _____
Patient, Parent, or Legal Guardian

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

Nature's Edge THERAPY CENTER INC

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

CASE HISTORY FORM

Patient Name: _____ Social Security Number: _____
Mother's Name: _____ Father's Name: _____
Diagnosis: Medical _____
Treatment _____
Referring Doctor's Name: _____ NPI: _____
Clinic Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Ext: _____

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

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

Nature's Edge
THERAPY CENTER INC

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

CONSENT FOR THERAPY, RELEASE OF INFORMATION, AND THERAPY PAY STATUS LETTER

Date: _____

To: _____

Therapy services are available to all patients at Nature's Edge Therapy Center, Inc. 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 these 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.

_____CASH
Patient will be seen _____ times per week for therapy. The amount of time in therapy may vary. Payment will be made in full in cash on the day of service. Such cash payment may include proceeds from grants/scholarships or fundraising undertaken by the patient's family. You will receive a monthly statement documenting all charges and amounts paid for that month.

_____PRIVATE PAY / PRIVATE INSURANCE
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: $200 CHARGE FOR THERAPY SESSION: $100

Please feel free to contact the therapist or the business office if you need further explanation before signing this approval. Please return a signed copy and 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, Inc., (3) you authorize the release of the patient's medical information to Nature's Edge Therapy Center, Inc. and for Nature's Edge Therapy Center, Inc. to release the patient's medical information for professional and claims purposes (upon written notice to the business office you may inspect or receive copies of such medical information upon payment of copying costs), (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 from third party payers within 60 days from the date of service, it remains the patient's responsibility and is immediately due in full. If not paid within 90 days from the date of service, interest will accrue on the unpaid balance at the rate of 1.8% per month.

PLEASE NOTE, CANCELLATION WITHOUT A 24-HOUR NOTICE WILL RESULT IN A CHARGE OF $100 (FOR EVALUATIONS) AND $50 (FOR THERAPY SESSIONS). THREE CANCELLATIONS WITHOUT NOTICE WILL RESULT IN TERMINATION OF THERAPY SERVICES.

Therapist's Signature	Date
Patient, Parent, or Legal Guardian	Date

Nature's Edge THERAPY CENTER INC

2523 14 ¾ Avenue Rice Lake, WI 54868 715.859.6670 phone 715.859.6669 fax

PATIENT INTEREST SURVEY

Name: _____

Age: _____ Date: _____ Grade Level: _____

School you attend: _____

What are your hobbies? _____

What do you hope to accomplish during therapy? _____

What activities are you most interested in participating in? _____

What is your favorite animal? _____

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

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