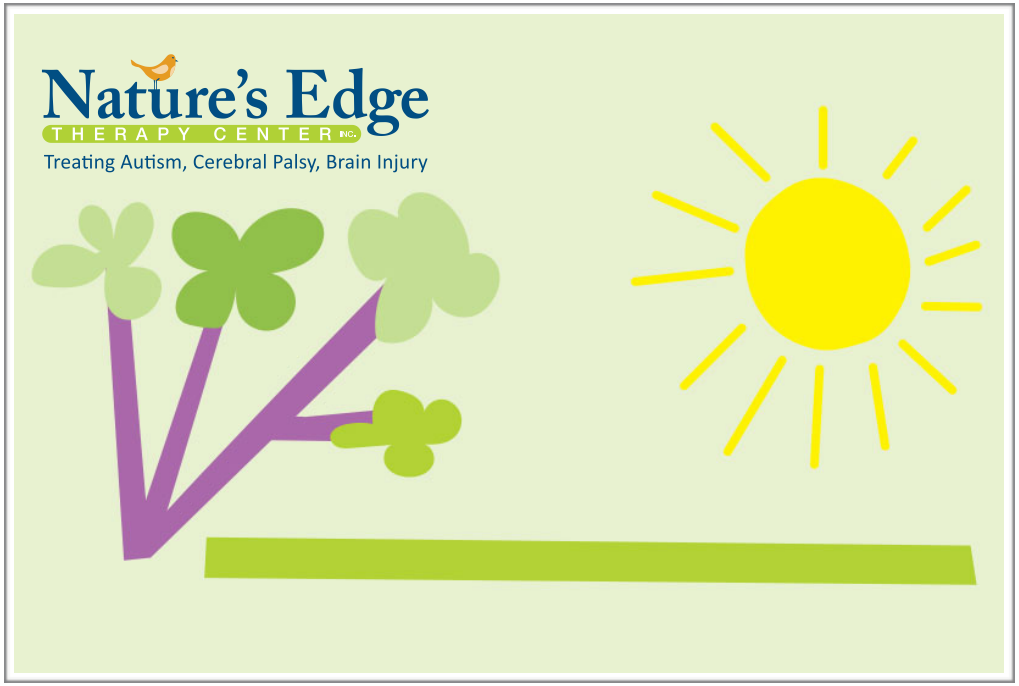


Patient Intake Form

Nature's Edge Therapy Center, Inc.

2523 14 ¾ Ave.
Rice Lake, WI 54868
Phone: 715-859-6670 · Fax: 715-859-6669
Email: nature@naturesedgetherapycenter.org
Website: www.naturesedgetherapycenter.org

Checklist – Patient Intake Process

The checklist below will guide you through the patient intake process at Nature's Edge Therapy Center. If you have any questions, please contact Nature's Edge by phone or by email. We're more than happy to help you!

- ☐ Form Sections
  - ○ Patient History, completed.
  - ○ Participation Agreement, completed and signed.
  - ○ Release Statements and Damage Agreement, signed.
  - ○ Hippotherapy Exclusion Agreement, signed.
  - ○ Authorization for Emergency Medical Treatment, completed and signed.
  - ○ Case History, Patient Interest Survey completed.
  - ○ Insurance Information, completed.
  - ○ Consent for Therapy, Therapy Pay Status and Release of Information Letter, completed and signed.
- ☐ Physician's Prescription for therapy services that includes diagnosis (and diagnostic code), stated in these terms:
  - ◉ Occupational Therapy/Speech Therapy/Physical Therapy (please name appropriate therapy) –To evaluate and treat as indicated.
- ☐ Current Individual Education Plan (IEP), if applicable, or other state or county care plans developed for the patient.
- ☐ Medical history and records from previous therapeutic treatments, if available.
- ☐ Application for Scholarship, if seeking scholarship assistance.
- ☐ Copy of Insurance Card.

Nature's Edge THERAPY CENTER INC.
Treating Autism, Cerebral Palsy, Brain Injury

Patient History

(To be completed by the patient or parent/legal guardian)

GENERAL INFORMATION

Patient's Name (Last)_____(First)_____
Date of Birth_____ M F
Age_____Height_____ Weight_____
Address_____
City_____State_____Zip_____
Telephone: Home_____ Work_____
Cell_____ Alternative _____

School/Employer_____
Address_____
City_____State_____Zip_____
Supervisor/Teacher_____Phone_____

Parent/Legal Guardian_____
If different from above:
Address_____
City_____State_____Zip_____
Telephone: Home_____ Work_____
Cell_____ Alternative _____

Referral Source_____

How did you hear about Nature's Edge?_____

_____

THERAPY HISTORY

1. Is the patient currently receiving *any* therapy services (physical, occupational and/or speech therapy) at any location (school, clinic, county, etc.)? ☐ Yes ☐ No

   If "yes," please indicate where_____
   Who is the therapist?_____
2. Has the patient had therapy (physical, occupational and/or speech therapy) in the past? ☐ Yes ☐ No

   If "yes," please indicate where_____
   Who was the therapist?_____
3. Please describe the patient's abilities/difficulties in the following areas, including assistance required or equipment needed:

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

_____

_____

_____

SOCIAL (work/school including grade completed, leisure interests, relationships/family structure, support systems, companion animals, fears/concerns, etc.) _____

_____

_____

_____

_____

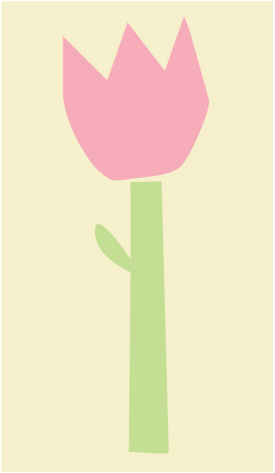
HEALTH HISTORY

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?_____

_____



GOALS – Why are you/the patient applying for treatment? What would you/the patient like to accomplish? _____

_____

_____

_____

_____

_____

_____

_____

Nature's Edge THERAPY CENTER INC.

Treating Autism, Cerebral Palsy, Brain Injury

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 home programs 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.

- *In order for your therapist to provide the best possible treatment for the patient, your therapist needs patient/caregiver cooperation and participation with a home program, carryover program, and with recommendations to be followed and charted or documented in the home setting, to determine measurable benefits or a modification in treatment strategy.* ***It is understood that should recommendations not be completed in three consecutive treatment sessions, the patient will be discharged from therapy.***
- *In order for your therapist to provide the best possible treatment for the patient, your therapist needs patient/caregiver cooperation with Nature's Edge in scheduling and attending prescribed and 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, THERAPY PAY STATUS, AND RELEASE OF INFORMATION LETTER for more information.*

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Release Statements

REGISTRATION AND GENERAL RELEASE

I, _____ (Patient's/Parent's/ Guardian's Name), hereby apply for participation in the therapy program at Nature's Edge Therapy Center. I acknowledge the risks and the potential for risks in 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.

_____ _____

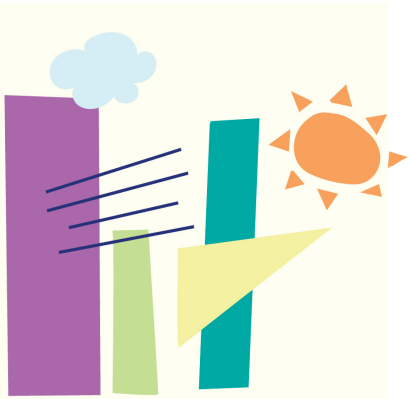
Signature of Patient, Parent, or Legal Guardian Date

HELMET RELEASE

I, _____ (Patient's/Parent's/ Guardian's Name), hereby give permission for Nature's Edge Therapy Center, Inc. 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



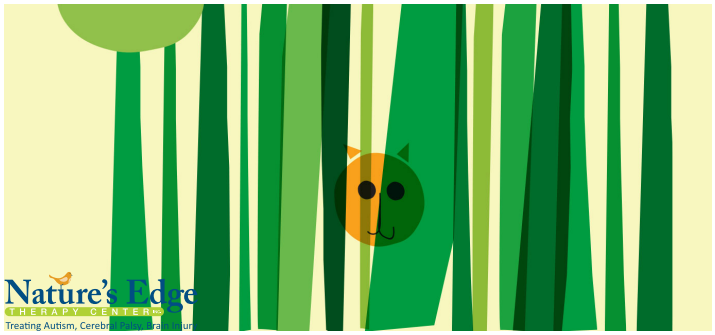
DAMAGE AGREEMENT

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 the 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 _____



Hippotherapy Exclusion Agreement

I understand that not all insurance providers will grant payment toward 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 the 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 _____

Authorization for Emergency Medical Treatment

In the event of an emergency, contact:

Name_____ Relationship_____ Telephone_____
Name_____ Relationship_____ Telephone_____

Consent Plan

In the event that 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 contacts 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) named above is unable to be reached.

Consent Signature:

_____ _____

Patient, Parent, or Legal Guardian Date

Non-Consent Plan

I do not give my consent for emergency medical aid/treatment in the case of illness or injury during the process of receiving services from, or while being on the property of, Nature's Edge Therapy Center, Inc. In the event that emergency medical aid/treatment is required, I wish the following procedures to take place: _____

_____

_____

_____

Non-Consent Signature:

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

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

Case History

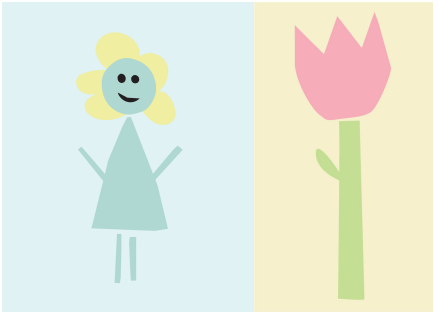
Patient's Name _____ SS# _____
Mother's Name _____
Father's Name _____
Medical Diagnosis _____
Treatment Diagnosis _____
Referring Physician's Name_____
Clinic Name_____
Address_____
City_____State_____Zip_____
Telephone: _____ Extension_____

Patient Interest Survey

Name _____Age _____
Birth Date_____ Grade Level_____
School you attend _____
Hobbies you enjoy _____
_____
Favorite Animals _____
What do you hope to accomplish during therapy? _____
_____
What activities are you interested in participating in? _____
_____
Previous Experience with animals? ☐ Yes ☐ No
Previous Experience with gardening? ☐ Yes ☐ No
If yes, please explain: _____
_____
_____

Nature's Edge THERAPY CENTER INC.
Treating Autism, Cerebral Palsy, Brain Injury

INSURANCE INFORMATION



Primary Insurance Company
Name_____
Address_____
City_____
State_____Zip_____
Policy #_____
Group #_____
Policy Holder Name
_____
Deductible/CoPay
_____
Telephone:
_____Ext._____
Onset Date
_____
Insurance Company Form/
Requirement? ☐ Yes ☐ No
If yes, please explain:
_____
_____
_____
_____

Secondary Insurance Company
Name_____
Address_____
City_____
State_____Zip_____
Policy #_____
Group #_____
Policy Holder Name
_____
Deductible/CoPay
_____
Telephone:
_____Ext._____
Onset Date
_____
Insurance Company Form/
Requirement? ☐ Yes ☐ No
If yes, please explain:
_____
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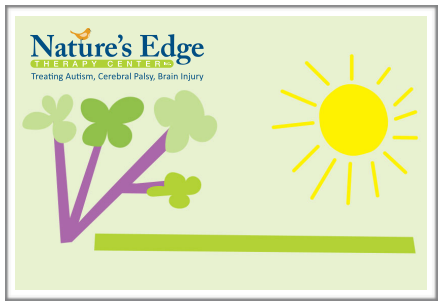
_____
_____



Consent for Therapy, Therapy Pay Status and Release of Information Letter

Date:

TO: _____

FROM: Nature's Edge Therapy Center, Inc.

Consent for Therapy

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

Therapy Pay Status

The item checked below is an explanation of the current payment source for the therapy services provided.

☐ *CASH/PRIVATE PAY.* Patient will be seen _____ times per week for therapy initially. Payment will be made in full on the day of service. Payment may include proceeds from grants/scholarships or personal fundraising. Scholarship copays are due on date of service. A monthly statement will be provided documenting all charges and amounts paid.

☐ *PRIVATE INSURANCE/OTHER AGENCY.* Patient will be seen _____ times per week for therapy initially. All charges and payments will be documented on a monthly statement. Any amounts not paid by third-party payers remain the patient's responsibility. Copays, deductibles, and co-insurance are due on the date of service.

CHARGE FOR EVALUATION: $350 **CHARGE FOR THERAPY SESSION: $175**

PLEASE 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 due in full immediately. If not paid in full within 60 days from the date of service, interest will accrue on the unpaid balance at the rate of 1.8% per month. 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. After 90 days from the date of service, unpaid balances may be submitted to collections.

YOUR SIGNATURE BELOW INDICATES THAT (1) you agree with the provisions of the payment source 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 (you may inspect or receive copies of such medical information upon written notice to the Business Office and payment of copying costs); (4) you authorize 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.

_____ _____

Signature of Therapist Date

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Please contact the therapist or the Business Office if you need further explanation before signing this approval. Your signature is required before we can proceed with therapy. Please return this signed letter and retain a copy for your records.