Buckaroo Barn L.L.C.

On behalf of Buckaroo Barn, LLC, we thank you for your interest in our physical therapy program for your physical therapy needs. We know you have many choices for your treatment, and we will strive to provide you with the highest quality care. Our physical therapy services require a physician's order, but our methods take our patient's therapy beyond the typical setting. We believe our program provides patients and families with functional skills and strategies for increased independence and integration well beyond traditional programs.

In order to determine the best action for your loved one with disabilities, we have enclosed some information for you to complete. Please follow these steps:

1. Fill out all forms prior to your first visit as completely as possible.
2. Obtain a prescription for physical therapy from your doctor that includes the following information:
    - The patient's name and date of birth
    - A statement that reads "Physical Therapy to Evaluate and Treat as indicated".
    - The current diagnosis(es) of the patient.
    - Contact information for the physician including address, phone, and fax number.
    - Physician's signature and date.
3. If your insurance provider is Medicaid, please include an EPSDT referral.
4. For an appointment, contact Buckaroo Barn, LLC, at 251-604-3904.

We provide one hour sessions Monday, Tuesday, and Wednesday, 8am-2pm, according to the treatment plan established from the evaluation. If you have any questions, please call 251-604-3904.

Arien Grosskurth
General Manager
Buckaroo Barn, LLC

Buckaroo Barn L.L.C.

# Patient Information

(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 _____ Email _____

Telephone: Home _____ Cell _____

School/Employer _____

Supervisor/Teacher _____ Phone _____

Physical Limitations (if any): _____

_____

Adaptive Equipment (circle all that apply): Orthotics Crutches Wheelchair Walker Other_____

Cognitive Limitations (if any): _____

_____

Communication Style (circle all that apply): Verbal Non-verbal ASL Communication Device Pictures

Other _____

Does this patient have any behaviors we need to be aware of? (Physical violence, tics, melt-downs, etc.) _____

_____

Does this patient have sensitivities or aversions to any specific textures, loud noises, bright lights, other?

_____

Parent/Legal Guardian _____

If different from above:

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work_____

Cell _____ Email _____

How did you hear about Buckaroo Barn, LLC? _____

_____

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# Therapy History

Patient's Name (Last) _____ (First)_____

1. Is the patient <u>currently</u> receiving *any* therapy services (physical, occupational, and/or speech therapy) at any location (school, clinic, county, etc.)? □ Yes □ No
    - If yes, please indicate where and the therapist: _____
      _____
      _____
2. Has the patient had therapy (physical, occupational, and/or speech therapy) <u>in</u> <u>the</u> <u>past</u>?
   □ Yes □ No
    - If yes, please indicate where and the therapist: _____
      _____
      _____
3. Please describe the patient's abilities/disabilities 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):
      _____
      _____
      _____
      _____
      _____
      _____

    - GOALS (i.e., Why are you applying for participation? What would you like to accomplish?): _____
      _____
      _____
      _____
      _____
      _____
      _____

Buckaroo Barn L.L.C.

# Patient Registration and Release Form

Patient's Name (Last) _____ (First)_____

Patient's Social Security Number _____ Date of Birth _____/_____/_____

Patient's Diagnosis _____

Parent(s) or Guardian: _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Work_____

Cell _____ Email _____

School/Employer _____

Physician _____ Phone _____

Address _____

**Primary Insurance Company**

Name _____

Address _____

City _____ State _____ Zip _____

Policy Number _____ Group Number_____

Policy Holder Name _____

Telephone: _____ Ext. _____

**Secondary Insurance Company**

Name _____

Address _____

City _____ State _____ Zip _____

Policy Number _____ Group Number_____

Policy Holder Name _____

Telephone: _____ Ext. _____

I give my consent for Buckaroo Barn, LLC, to verify all of the information that I have provided above. I also authorize the Physical Therapist on staff to obtain any other information that is necessary to carry out treatment.

_____ _____/_____/_____

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 Buckaroo Barn, LLC. 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 Buckaroo Barn, LLC, its therapists, instructors, aides, volunteers, and/or employees, and the Chastang properties, 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 (Initial and sign next to YES or NO)

_____ (YES) I consent to and authorize the use and reproduction by Buckaroo Barn, LLC, 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 Buckaroo Barn, LLC.

_____ (NO) I do NOT consent to the above photo release.

_____ _____/_____/_____

Signature of Patient, Parent, or Legal Guardian Date

HELMET RELEASE

I, _____ (Patient's/Parent's/Guardian's Name), hereby give permission for Buckaroo Barn, LLC, 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 Buckaroo Barn, LLC, its therapists, instructors, aides, volunteers, and/or employees, and the Chastang properties, of any and all injuries and/or losses the patient, patient's family, or guests may sustain while not wearing a helmet.

_____ _____/_____/_____

Signature of Patient, Parent, or Legal Guardian Date

Buckaroo Barn L.L.C.

# 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 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 Buckaroo Barn, LLC, 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.

_____ _____/_____/_____

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 Buckaroo Barn, LLC, 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 Buckaroo Barn, LLC, or the Chastang family, while on premises of Buckaroo Barn, LLC, and/or for the loss of use of such property resulting from any damage, caused by my negligence or that of any children, guests, or animals brought on such premises by me. I further agree to pay for any necessary repairs or to reimburse Buckaroo Barn, LLC, and/or the Chastang 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

Buckaroo Barn L.L.C.

# Authorization for Emergency Medical Treatment

Patient's Name (Last) _____ (First)_____

In the event of an emergency, contact:

Name _____

Relationship _____ Phone # _____

Name _____

Relationship _____ Phone # _____

**Consent Plan**

In the event of an 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, Buckaroo Barn, LLC, and the above contacts cannot be reached, I authorize Buckaroo Barn, LLC, 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 procedures 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

_____ _____/_____/_____

Signature of Patient, Parent, or Legal Guardian Date

**Non-Consent Plan**

I do not give my consent for 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, Buckaroo Barn, LLC. 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

Buckaroo Barn L.L.C.

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

Patient's Name (Last) _____ (First)_____

**Consent for Therapy**

Therapy services are available to all patients at Buckaroo Barn, LLC., and are provided by licensed physical 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. The patient will be seen 1 time per week for therapy initially. Payment will be made in full on day of service. Payment may include proceeds from grants/scholarships or personal fundraising. A monthly statement will be provided documenting all charges and amounts paid.

☐ Private insurance/other agency. The patient will be seen 1 time 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 date of service.

☐ Medicaid. The patient will not be responsible for payments if Medicaid approves services. If Medicaid does not approve services, the account will automatically become private insurance or private pay and the patient will be responsible for all deductibles, co-pays, and uncovered services.

**Please Note**: Buckaroo Barn, LLC, 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, a late payment fee of $25 will be added every 30 days. **Cancellation without 24-hour notice or a no-show will result in a charge of $50.** 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 Buckaroo Barn, LLC,; (3) you authorize the **release of the patient's medical information** to Buckaroo Barn, LLC, and for Buckaroo Barn, LLC, to release the patient's medical information for professional and claims purposes (you may inspect or receive copies of such medical information); (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 Patient, Parent, or Legal Guardian Date

Buckaroo Barn L.L.C.

# Current Medical Status

(Must be completed by a Health Care Provider/Physician)

Patient's Name (Last) _____ (First)_____

Date of Birth ___/___/_____ M F Age _____ Height _____ Weight _____

Address _____City _____ State _____ Zip _____

Diagnosis _____ Date of Onset _____

Medications _____

Please indicate any special precautions: _____

Indicate if the patient has issues and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

| Areas | Yes | No | Comments |
|---|---|---|---|
| Vision | | | |
| Hearing | | | |
| Sensation | | | |
| Communication | | | |
| Heart | | | |
| Breathing | | | |
| Digestion | | | |
| Elimination | | | |
| Circulation | | | |
| Emotional | | | |
| Behavioral | | | |
| Pain | | | |
| Bone/Joint | | | |
| Muscular | | | |
| Thinking/Cognition | | | |
| Allergies | | | |
| Other | | | |

** For Downs Syndrome Patient Only – □ Annual Medical Exam including a complete Neurological Exam has been given that specifically denies any symptoms consistent with Atlantoaxial Instability. Date of exam ___/___/___

To my knowledge there is no reason this person cannot participate in supervised equestrian activities. However, I understand that the Buckaroo Barn, LLC., will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional in implementing an effective therapy program.

Physicians Name (please print) _____

Physicians Signature _____

Address _____

Phone _____ Date _____/_____/_____