



THERAPYWORKS NW

Physical, Occupational & Speech Therapy

www.therapyworksnw.com • 503-663-0481 • Fax 503-663-0480 • 7927 S.E. Orient Drive, Gresham, OR 97080

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (1): _____

Address _____ City _____ State _____ Zip _____

Home Phone #: _____ Cell: _____ Work: _____

Parent/Guardian Name (2): _____

Address _____ City _____ State _____ Zip _____

Home Phone #: _____ Cell: _____ Work: _____

Parent/Guardian Email(s): (1) _____ (2) _____

Emergency Contact _____ Phone: _____

Emergency Contact Relationship to Patient: _____

Patient's diagnosis/diagnoses (if known): _____

Primary Care Physician: _____ Office Name: _____

Patient Status: Foster Child Adopted Bio

Case Worker Name (if Foster): _____ Phone: _____

Primary Insurance Company Name _____

Subscriber Name _____ Date of Birth _____

Policy/ID #: _____ Group Number: _____

Secondary Insurance Company Name _____

Subscriber Name _____ Date of Birth _____

Policy/ID #: _____ Group Number: _____

Assignment and Release:

I give consent for TherapyWorks NW to evaluate and treat myself or the above named child to whom I am parent or legal guardian. I also assign directly to TherapyWorks NW, or Bobbi Culter, any insurance benefit that would be otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize TherapyWorks NW to release all information necessary to secure the payment of benefits, and do authorize the use of this signature on all insurance submissions. I also hereby authorize TherapyWorks NW to release all information necessary to report to a referring physician of the above named patient. I acknowledge that any other sharing of my medical information may only be done with my separate signed consent.

Parent or Legal Guardian Signature

Parent or Legal Guardian Name

Date

PICK-UP/DROP-OFF

Please indicate below who is approved to pick up and/or drop off your child from their therapy appointments:

Patient Name: _____ Date of Birth: _____

Name (First & Last)	Relationship to Patient	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: If your child will be dropped off or picked up from their appointment(s) by someone not indicated by you (parent/guardian) on the above list, you must notify us and provide the name and phone number of the person who will be present with your child before their appointment.

Parent or Legal Guardian Signature

Parent or Legal Guardian Name

Date

BACKGROUND INFORMATION

Child's Name: _____ Sex: M / F Age: _____ Grade/Level: _____

School Attended: _____ Teacher's Name: _____

Main Concerns: _____

What would you like to accomplish through therapy? _____

History

Ethnicity/Ethnicities: _____ Languages spoken in home: _____

Age(s) and gender of sibling(s): _____

Complications, illness/ infections/stress during pregnancy? Y / N (describe): _____

Complications during labor and delivery? Y / N (describe): _____

Forceps / Vacuum / C-section? Y / N Birth Order _____ Birth Weight _____

Premature / Postmature / Full Term ? (circle one) Apgar score at 1 min. _____ 5 min. _____

Breast Fed? Y / N How Long? _____ Strong Suck? Y / N Spit up frequently? Y / N

Problems with Feeding / Respiration / Sleeping ?(circle) (describe): _____

Irritable / Happy / Quiet baby? (circle) Arch back and head when upset? Y / N

Developmental Milestones: Please note approximate age at which he/she did the following:

Sat _____ Belly Crawled _____ Crawled _____ Cruised _____ Walked _____ Said first words _____

Talked _____ Toilet trained (bladder) _____ (bowels) _____ Undressed self _____

Dressed self _____ Managed snaps, zippers, buttons _____ Tied shoes _____ Started preschool _____

Ear Infections? Y / N (How many, what ages?) _____

Preferred hand: L / R ? Age established? _____

Allergies? Y / N _____

Seizures? Y / N _____

Injuries? Y / N _____

Hospitalizations? Y / N _____

Glasses? Y / N (condition) _____

Medications Y / N _____

Other precautions or concerns: _____

PARTICIPANTS RELEASE AND HOLD HARMLESS AGREEMENT

By signing this form, I acknowledge that therapeutic and pleasure horse riding has the possibility of being a dangerous activity which may result in injury. With this knowledge, in consideration for the services of Bobbi Culter P.T. and/or any person associated with the business TherapyWorks NW, and as inducement for the services of Bobbi Culter P.T. and/or any person associated with the business Therapyworks NW to provide therapeutic horse riding and /or physical therapy and or occupational therapy on horseback for me or my child to whom I am parent or legal guardian, I hereby waive, release, discharge and hold harmless Bobbi Culter and/or the business TherapyWorks NW for any and all liability for damages sustained by me, or by my other family members accompanying me to the therapy site, or for any item or person under my dominion and control. This same waiver, release, discharge and hold harmless statement applies to Bobbi Culter P.T. and the business Therapyworks NW to include its officers, directors, employees and volunteer assistants, their heirs, executors, administrators, successors or assigns. Without limiting the generality of the above, I hereby waive and release TherapyWorks NW, its officers and directors and all volunteer assistants for liability based on the active or passive negligence of said persons and entities.

I hereby agree to indemnify and hold harmless Bobbi Culter P.T. and TherapyWorks NW, its officers, directors and all volunteer assistants associated therewith for nay claim which may be made against them, including attorney's fees and costs of suit in any action based upon or arising from my acts or omissions, or the actions of any animal involved.

I _____, the undersigned parent or legal guardian of (Child's Name) _____ for and in consideration of my child's participation at TherapyWorks NW for hippotherapy services state that I have read the waiver, release and hold harmless written above and I expressly agree that the terms and conditions of said waiver, release and hold harmless shall apply to and be binding upon me and my minor child as a result of said participation. I further warrant that I have health insurance for said minor.

Print Name

City, State

Signature

Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize TherapyWorks NW to:

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

Patient's Name: _____ DOB: _____

Address: _____

In the event that I cannot be reached:

Emergency Contact 1: _____ Phone: _____

Relationship to Patient: _____

Emergency Contact 2: _____ Phone: _____

Relationship to Patient: _____

Physician's Name: _____

Health Insurance Co. _____ Policy/Member #: _____

Consent or Non-Consent to Emergency Medical Treatment (mark one option)

Option A: [] I **do** give consent for emergency medical treatment/aid in the case of illness or injury.

This Authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician.

Signature: _____

Date: _____

Parent or Guardian

This provision will only be invoked if the person below is unable to be reached:

Name: _____ Relationship to patient: _____ Phone: _____

Option B: [] I **do not** give consent for emergency medical treatment/aid in the case of illness or injury.

In the event of an emergency, I wish the following to take place:

Signature: _____

Date: _____

Parent or Guardian

Photo Release (mark one option) [] I **consent** to and authorize OR [] I **do not consent** to and do not authorize the use and reproduction by TherapyWorks NW of any and all photographs and any other audio-visual materials taken of me or my child for promotional material, educational actives, exhibitions or for any other use for the benefit of the therapy program.

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.

Patient Name

Parent/Guardian Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify)

CANCEL AND NO SHOW POLICY

Regular attendance in therapy is important to your child's developmental outcome. Notification of absences for illness or other conflicts is also critical to the scheduling success of TherapyWorks NW. Given the complexity of scheduling, a lot of effort is made by our office manager to coordinate your child's care across our various therapy offerings.

Therefore as of January 1, 2017 **TherapyWorks NW does require a 24 hour notification if your child will have to miss an appointment.** Failure to make this notification and/or repeated absences without notification will be subject to any or all of the following new policy guidelines:

1. A \$25 fee may be charged (*PER missed appointment*) that must be paid prior to returning to therapy. This means if your child misses Physical, Occupational, and Speech therapy appointments, this would incur a \$75 total fee.
2. Your child's regular appointment time may not be saved and you will be put onto an on call list for openings in cancellations that happen within your time availability.
3. Your child's regular appointment time may not be saved and an alternate regular time may be offered.
4. Your child will be discharged from therapy, but will be welcome to return when regular attendance and notification of absences is possible.

TherapyWorks NW also requests that you call to cancel when your child has had fever, diarrhea or vomiting within the last 24 hours.

Agreement Statement:

I, the parent or guardian of _____,
do agree to abide by the above stated policy.

Printed Name

Signature

Date