OCCUPATIONAL THERAPY SERVICES

Strides

Client's Consent for Treatment

Client Name: _____

Authorization for Treatment

I consent to the evaluation and treatment necessary for the above named client, including occupational therapy and/or any other related services that the provider advises to be necessary.

Patient Responsibility

It is the client/parent/guardian's responsibility to inform Strides Occupational Therapy Services, Inc. of all medical conditions, outside treatments, and medications at the initial evaluation.

It is the client/parent/guardian's responsibility to inform Strides Occupational Therapy Services, Inc. of any change in medical condition or insurance status (including change of company and / or termination of policy, etc).

HIPPA Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 often referred to as HIPAA, I have certain rights to privacy regarding my/my child's protected health information and how it will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as assessing quality of treatment and review of healthcare professionals.

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment and for health care operations such as quality reviews. I have been informed that I may review the practice/clinic's Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent. I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic. I understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my request restriction, they must follow the restriction(s). I also understand that I may revoke this consent at any time by making a request in writing, except for information already used or disclosed.

Restrictions

_____

_____

Signature: _____ Date: _____

Print Name: _____ Relation to Client: _____

OCCUPATIONAL THERAPY SERVICES

Strides

Client's Consent for Release of Information

I hereby authorize Strides Occupational Therapy Services, Inc. to release information from the records of:

_____ DOB:_____

(participant's name)

The information may be released to:

Physician: _____

Therapist/Therapy Center: _____

School: _____

Insurance Agency: _____

Other: _____

Other: _____

for the purpose of developing a program, discussing progress towards goals, and/or billing insurance for the above named client.

This release is valid for the duration of services and can be revoked, in writing, at my request.

Signature: _____ Date: _____

Print Name: _____ Relation to Client: _____

I understand that:

1. I may revoke this authorization at any time in writing, except to the extent that action has been taken based upon it;
2. The recipient of these records may further disclose this information and it may then no longer be protected by federal privacy regulations;
3. I am entitled to a copy of this document;
4. I may refuse to sign this authorization and my refusal to sign will not affect treatment, payment, enrollment, or eligibility for benefits;
5. This authorization shall expire upon my written request to revoke or according to state law;
6. A copy of this authorization is valid as the original.

OCCUPATIONAL THERAPY SERVICES

Strides

Authorization for Emergency Medical Treatment

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury while participating in Strides Occupational Therapy Services: I authorize Strides OT to secure and retain medical treatment and transportation if needed. This authorization includes but is not limited to x-ray, surgery, hospitalization, medication and any treatment deemed "life-saving" by the physician. In addition, I authorized Strides OT to release my records to any individual involved in medical treatment and/or transportation I might need. This provision will be invoked only if the emergency contact person(s) listed below is/are unable to be reached.

Date: _____ Participant's Name (print): _____ DOB: _____

Phone Number: _____ Alternative Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

In case of emergency, contact:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Physician Name: _____ Phone Number:_____

Preferred Medical Facility: _____ Allergies: _____

Current Medications: _____

Last Tetanus Shot: _____ Tuberculosis Test: + / - Date: _____

Health Insurance Company: _____ Policy Number: _____

Consent Authorized Signature: _____ Date: _____
(Parent/Legal Guardian/Participant if over 18)

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment in the case of illness or injury while participating in Strides Occupational Therapy Services. In the event of emergency treatment is required, I wish the following procedures to take place: (list procedures) _____

_____

Date: _____ Participant's Name (print): _____

Non-Consent Authorized Signature: _____ Date: _____
(Parent/Legal Guardian/Participant if over 18)

OCCUPATIONAL THERAPY SERVICES
Strides

RELEASE AND ASSUMPTION OF RISK AGREEMENT

I agree to the following Release and Assumption of Risk Agreement with STRIDES OCCUPATIONAL THERAPY SERVICES, INC. (hereafter referred to as "STRIDES OT") as a condition for allowing me or my child /legal ward identified below to enter STRIDES OT's premises, surrounding land, and other program locations, be near horses, participate in equine-assisted activities, work near horses, handle horses, use equipment, work with staff and volunteers, and/or receive instruction or guidance while riding, driving, grooming, or handling horses. This is not meant to be a complete list of all activities and will be referred to in this document as "The Activities".

IT IS HEREBY AGREED AS FOLLOWS:

1. I have voluntarily requested, for myself or for my child/legal ward identified below, to engage in any or all of The Activities, now and/or in the future.
2. **Risks**. I understand that anyone engaging in The Activities can suffer bodily injuries, property damage and other injuries including death. Participation in The Activities involves certain inherent risks and, regardless of the care that is taken, it is impossible to ensure the safety of the participant*. I understand the risks/dangers inherent in The Activities, and I agree to assume them. I am not relying on STRIDES OT to list all possible risks for me or my child/legal ward.*
3. **Waiver and Liability Release:** As consideration for STRIDES OT allowing me or my child/legal ward to engage in The Activities at any time and at any location, I do hereby voluntarily assume all risks of loss, damage or personal bodily injury including death that may be sustained which may hereinafter occur on account of, or in any way arising from, entry upon the premises or participation in The Activities on or off the premises. I, for my heirs, administrators, personal representatives, or assigns, release and discharge STRIDES OT, and all STRIDES OT employees, assistants, directors, volunteers, instructors, officers, and owners of horses from any and all claims, demands, damages, actions, omissions, suits, or causes of action (present or future).
4. **Indemnification:** I also understand and agree to indemnify and hold harmless STRIDES OT and persons or entities working on behalf of or affiliated with STRIDES OT against any and all further claims or damages, cost or expenses incurred by STRIDES OT and their employees as a result of an accident, injury or property loss which may occur while I, or my child/legal ward are on or off the premises or engaged in The Activities connected with STRIDES OT which may result from negligence of the undersigned or the negligence of STRIDES OT, employees, volunteers, instructors, agents, third parties or any combination thereof of STRIDES OT. The indemnification shall include reimbursement of STRIDES OT's attorney fees.
5. **ASTM/SEI Headgear:** STRIDES OT will provide me or my child/legal ward with an equestrian safety helmet that is ASTM standard and SEI-certified for use when riding horses. I understand that neither STRIDES OT nor its assistants or agents can guarantee the suitability of any helmet provided.
6. **Health and Disabilities:** I understand that STRIDES OT always recommends that I seek the advice of a physician if I or my child/legal ward is injured, and many of The Activities pose special physical risks to the participant .
7. Should I breach this Release (or any part of it) I agree to pay the attorney's fees and court costs related to such breach incurred by STRIDES OT and/or persons directly affiliated with STRIDES OT. It is also mutually agreed that any disputes arising under this Release, or any activities that are undertaken pursuant to this document, shall be litigated in a court of proper jurisdiction located in or nearest to Lee County, Florida.

I understand that when signed, this Agreement is intended to be legal, valid and binding at all times, now and in the future, when STRIDES OT permits me or my child/legal ward to engage in any or all of The Activities either on the STRIDES OT premises or other designated program locations.

WARNING: Under Florida Law, an equine activity sponsor or equine professional is not liable for an injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.

NAME OF PARTICIPANT _____

SIGNATURE OF PARTICIPANT IF 18 OR OLDER _____

DATE _____ ADDRESS _____

PHONE _____ EMAIL _____

I hereby certify that I am authorized to sign this Release and Assumption of Risk Agreement on behalf of the Participant.

NAME OF PARTICIPANT _____

SIGNATURE OF PARENT OR LEAGAL GUARDIAN

_____

DATE _____ ADDRESS _____

PHONE _____ EMAIL _____

OCCUPATIONAL THERAPY SERVICES

Strides

Photo/Media Release

Client Name: _____

I _____ DO _____ DO NOT consent to and authorize the use and reproduction by Strides Therapy Services, Inc. of any and all photographs and any other audio /visual materials taken of me, my family, or my child who is a client of Strides Occupational Therapy Services, Inc. for promotional material, educational activities, exhibitions or for any other use.

Signature: _____ Date: _____

Print Name: _____

Relation to Client: _____

Payment Agreement

I understand that the fee for service is due by cash, credit card, or check at the time of treatment, unless prior arrangements have been made. Paperwork for submittal of insurance claims may be requested.

I understand and accept ultimate responsibility for payment of my account with Strides Occupational Therapy Services, Inc.

I have read and understand this policy.

_____ _____

Signature Date

_____

Print Name

Cancellation Policy

Cancellations/Makeups: I understand that if I must cancel a session, a 24-hour notice is required. I understand that failure to notify Strides Occupational Therapy of a cancellation 24 hours ahead of time will result in the normal cost of a therapy session to be charged. I also understand that I may reschedule any cancelled therapy sessions. We recognize and assess individual needs. Excessive cancellations may cause a loss of reserved time.

I have read and understand this policy.

_____ _____

Signature Date

_____

Print Name

OCCUPATIONAL THERAPY SERVICES

Strides

Name: _____

Date: _____

Medications/Allergies/Diet

Medication	Purpose/Reason Taken	Dose	Time(s) of Day Taken	Prescribing Doctor

Allergies

Special Diet