Epona Therapy Services, LLC

Patient Information Packet

Patient Name	Date of Birth / /	Age	Weight	Height ft in	Gender ☐ M ☐ F
Parent/Guardian (if under 18)	Parent DOB / /	School			Grade
Address	City			State	Zip Code
Email Address	Home Phone ( )		Cell Phone ( )		
Other Caregiver	Caregiver's Phone Number ( )				

Would you like to receive emails from us? ☐ Yes ☐ No

How should we contact you for appointment reminders? ☐ Email ☐ Text ☐ Call (Cell) ☐ Call (Home)

How did you hear about us?

Photo/Video Release Form

I hereby consent to and authorize the use and reproduction of any and all photographs and any other audiovisual material taken of me, my child and/or family. Photos/videos may be used for promotional materials, educational seminars, exhibitions, website, e-newsletters, videos and press releases. Photo/videography can be taken at the farm during my child's therapy session and at educational activities or for any use for the benefit of Epona Therapy Services.

I hereby: (choose one) □ **consent** to and authorize *or* □ **do not consent** to or authorize the use and reproduction of any and all photographs and any other audiovisual materials taken of me/my child by Epona Therapy Services, LLC for promotional printed material, educational activities, website, Facebook, PATH Intl., AHA. Inc, EAGALA and exhibitions, or for any other use for benefit of Epona Therapy Services, LLC.

Participant/Legal Guardian Signature: _____ **Date**: _____ LLC.

Name: _____Date: _____

Consent: _____ Non-consent: _____

Signature: _____

Thank you for your participation and support in helping promote Epona Therapy Services, LLC

Health History

Diagnosis	Date of Onset
	/ /

Primary Care Physician	Referring Physician

Past/Prospective Surgeries	Up to Date on Vaccinations?
	Yes ☐ No ☐

Medications

Seizure Type	Controlled	Frequency	Duration	Date of Last
	Yes ☐ No ☐			/ /

Shunt Present	Date of Last Revision	Special Precautions/Needs
Yes ☐ No ☐	/ /	

Symptom	Yes	No	Comments: Please describe any needs or concerns
Auditory/Hearing			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary/Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Other			

Atlantoaxial Instability Disclosure :

Epona Therapy Services , LLC requires that individuals with Down syndrome be fully examined for atlantoaxial instability. Once a negative baseline is established, further X-rays are at the discretion of the parents and physician.

Date of X-rays	Radiologist	Results	Neurological Symptoms
/ /		☐ Positive ☐ Negative	☐ Present ☐ Absent

Financial Policy Acknowledgement

The purpose of this Insurance Statement is to make you aware of your obligations, as well as limitations on the obligations of Epona Therapy Services, LLC, regarding potential insurance coverage for occupational therapy provided to you by Epona Therapy Services("Services"). The Services may include, but are not limited to, occupational therapy using treatment strategies such as sensory integration, DIR/Floortime, Neurodevelopmental Techniques (NDT), hippotherapy, equine assisted therapy, or equine movement.

EXPLANATION OF INSURANCE COVERAGE

Insurance policies vary greatly in terms of what they cover and, for services and expenses that they do cover, the deductible amount and percentage of coverage provided. Many insurance policies cover (and do not exclude) all or part of the Services; however, Epona Therapy Services, LLC makes no representation that any insurance policy you have covers (or does not exclude) the Services. Please understand that your insurance policy is a contract between you and your insurance provider. Epona Therapy Services, LLC is not a party to that contract.

RESPONSIBILITIES AND LIMITATIONS

Because of how much one insurance policy varies to another, we require that you determine whether, and to what extent, your policy covers the Services. This determination should be made as soon as possible and include a review of any relevant exclusions in your policy. You should therefore consider requesting a list of policy exclusions, as well as a pre-estimate of benefits, from your insurance provider.

After payment is received by Epona Therapy Services, LLC for the Services (which is due from you at the time the Services are provided), we will provide you with proof of payment and any applicable codes for the Services. Epona Therapy Services, LLC does not recommend that you submit any proof of payment or codes to your insurance provider for any portion of the Services that are clearly excluded in your policy. You accept full financial responsibility for the Services (including any balance remaining after insurance reimbursements and adjustments).

You are also responsible for working with your insurance provider to address any questions or requests they have regarding a claim. If your insurance provider denies all or part of a claim that you make, it is your responsibility to work with them to understand what rights you may have, which could include the ability to appeal any decision made.

Epona Therapy Services, LLC is available to answer any questions that you or your insurance provider may have regarding the Services and, at your request and with your consent, will provide records that we have related to the Services. You are responsible for obtaining and providing any necessary doctor referral paperwork.

Subject to all rights and protections afforded to you by law, you accept responsibility for any problems that arise during any attempt to obtain coverage or reimbursement for the Services from your insurance provider. You agree to not look to Epona Therapy Services, LLC for financial compensation related to any dispute with your insurance provider.

By signing below, I certify that any service rendered by Epona Therapy Services, LLC for the above will be paid by me, the Responsible Party. I understand that all services rendered by Epona Therapy Services, LLC **must be paid within 15 days of invoice date** to prevent interruption of services and to avoid 10% monthly interest charges. Accounts over 90 days past due will be forwarded to credit reporting collections agency. Once the account is forwarded to said agency, a 25% fee will be assessed on any owed balances.

Signature of Responsible Party/Guarantor	**Date** / /
Printed Name of Responsible Party/Guarantor	

Attendance Policy

While we understand that illness and family emergencies do arise, prompt and regular attendance to scheduled therapy visits is critical in order to get the best results for your child.

Cancellations:

Notice of cancellation is required **at least 24 hours in advance of scheduled appointment** by notifying your therapist directly **and** calling the office at (732) 595-8515 in order to avoid a cancellation fee.

Less than 24 hour notice or a **no show** will result in automatic billing of cancellation fees as follows: $100 fee per session

Consent to Treat/Liability Waiver

I authorize Epona Therapy Services, LLC and designated personnel to provide treatment as deemed necessary by my therapist. Patient and Responsible Party represent that patient has no condition that would indicate therapy is contraindicated or inappropriate at this time. This representation is made knowing that Epona Therapy Services, LLC will rely upon same representation for all therapeutic activities offered. I certify I will disclose any information related to change in status and will keep medical information on file current. Patients and guests using the facilities and equipment do so at their own risk. Epona Therapy Services, LLC shall not be liable for any damages arising from personal injuries or damages sustained in, on or about any Epona Therapy operating location. Patient and Responsible Party assume full responsibility for any injuries or damages and do hereby and forever release and discharge Epona Therapy Services, LLC from any and all claims, demands, damages, rights or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the patient's, family's or guests' use of intended use of the facilities and/or equipment.

Signature of Responsible Party/Guarantor	**Date** / /
Printed Name of Responsible Party/Guarantor	

HIPAA Compliance/Confidentiality Policy

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. A copy of the full disclosure can be found on our website.

I authorize the following persons to have access to my record and/or to contact Epona Therapy Services, LLC on my behalf:

Name/Relationship
Name/Relationship
Name/Relationship
Name/Relationship

Emergency Contact and Authorization

Epona Therapy Services, LLC shall only disclose information to outside agencies/individuals with the specific written consent of the client/legal representative. In cases of medical emergency due to illness or injury while receiving services rendered by Epona Therapy Services, LLC or while receiving services, this policy shall recognize the required Authorization for Emergency Medical Treatment as such required written consent. Epona Therapy Services, LLC requires separate written consent for outside informants. In case of emergency, Epona Therapy Services, LLC policy is to call 911 and to initiate CPR until EMS arrives.

In the event of an emergency, contact:

Name	**Relationship**
Phone Number ( )	**Alternate Phone Number** ( )

By signing below, I acknowledge receipt and understanding of the policies above.

Signature of Responsible Party/Guarantor	**Date** / /
Printed Name of Responsible Party/Guarantor	

Consent for Release of Information

I hereby authorize:

Outside Person or Facility e.g. Pediatrician or Other Therapist

to release information from the records of:

Patient's Name	**Date of Birth**
	/ /

The information is to be released to Epona Therapy Services, LLC for the purpose of developing an integrated therapy treatment plan for the above named client. The information to be released is indicated below:

- ☐ **Medical History**
- ☐ **Physical therapy evaluation, assessment, and program plan**
- ☐ **Occupational therapy evaluation, assessment, and program plan**
- ☐ **Speech therapy evaluation, assessment, and program plan**
- ☐ **Mental health diagnosis and treatment plan**
- ☐ **Individual Habilitation Plan (IHP)**
- ☐ **Individualized Family Service Plan (IFSP)**
- ☐ **Classroom Individual Education Plan (IEP)**
- ☐ **Psychosocial evaluation, assessment, and program plan**
- ☐ **Cognitive-behavioral management plan**
- ☐ **Other**

This release is valid for one year and can be revoked, in writing, at my request.

I also hereby consent to provide pertinent medical information/paperwork clearly documenting the need for and clearance to begin physical, occupational, or speech therapy in the occurrence of any medical status change i.e., hospitalization, surgery, or other medical procedure.

Signature	**Date**
	/ /
Printed Name	**Relationship to Patient**

Please send materials to

- ☐ **Email**: EponaTherapy@gmail.com