Clinic Address
2200 Hamner Ave. Ste. 107
Norco, CA 92860
(951) 340-0431

LEAPS & BOUNDS
PEDIATRIC THERAPY

Patient Information

Last Name:_____ First Name:_____ Middle I:___

Date of Birth: ____/___/_____ Gender: M/F SS#_____

Father's Name: _____ Mother's Name: _____

Father's Date of Birth: ___/___/___ Mother's Date of Birth: ___/___/___

Current Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Preferred Means of Contacts: ____ Email ____ Cell ____ Home

Can we send you emails regarding your child? _____ Yes _____No

Referred By:_____

Responsible Party SS#:_____ Responsible DL:_____

Employer (Father/Mother):_____

Is your child a client of Regional Center: Yes No Unsure Date of Last IFSP:_____

If yes: Name of Service Coordinator:_____ Phone #:_____

Primary Care Physician or Pediatrician:_____

Address:_____

Phone:_____ Fax:_____

Primary Insurance:_____ Name of Subscriber:_____

ID#:_____ Group#:_____

Secondary Insurance:_____ Name of Subscriber:_____

ID #:_____ Group#:_____

_____ _____

Parent/Guardian Signature Date

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PEDIATRIC THERAPY

Clinic Phone
(951) 340-0431

Past Medical History

Last Name: _____ First Name:_____ Middle I:___

Pregnancy and Birth History

Was your child born full term? Yes or No If no, how many weeks gestation?___

Were there any extraordinary conditions during the pregnancy? Yes or No

(Examples: High fever, infection, prescription medications, high blood pressure, etc.)

If yes, please describe:_____

Were there any extraordinary conditions during or after the birth? Yes or No

If yes, please describe:_____

Child's Health History

Immunization Current? Yes or No

Allergies? Yes or No If yes, please describe:_____

Hospitalizations? Yes or No If yes, please describe:_____

Surgeries? Yes or No If yes, please describe:_____

Other?_____

Is your child taking any medication? Please list:_____

_____

What are your concerns about your child?_____

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

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LEAPS & BOUNDS
PEDIATRIC THERAPY

Authorization to Release Information

I,_____, as the Parent/legal guardian to _____, do hereby authorize the staff of Leaps & Bounds Pediatric Therapy, Inc. to communicate with the following physicians/ entities regarding Protected Health Information (PHI) as necessary while receiving physical, occupational or speech therapy services.

Patient Name:_____

Patient Date of Birth:___/___/___

Authorizing communication regarding PHI with the following:

Name:_____

Address:_____

Phone:_____

Name:_____

Address:_____

Phone:_____

Name:_____

Address:_____

Phone:_____

_____

Parent/Guardian Signature Relationship Date

_____

Witness Date

2200 Hamner Ave. Ste. 107
Norco, CA 92860

Phone: (951) 340-0431
Fax: (951) 893-5135

Patient Photo Release Agreement

I, _____ give my permission to use my child's name, _____, likeness, image, voice, and/or appearance as such may be embodied in pictures, photos, video recordings, audiotapes, digital images, and the like, take or make on behalf of Leaps & Bounds Pediatric Therapy Inc. I agree that Leaps & Bounds Pediatric Therapy Inc. has complete ownership of such pictures, etc. including the entire copyright and may use them for any purpose consistent with the Leaps & Bounds Pediatric Therapy program mission. These uses include, but are not limited to: illustrations, bulletins, exhibitions, video tapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials and any other mediums including the internet. I acknowledge that I will not receive any compensation, etc for the use of these pictures etc. and hereby release Leaps & Bounds Pediatric Therapy Inc. and any of its agents and assigns from any and all claims which arise our of or are in any way connected with such use.

I have read and understood this consent and release.

I give my consent to Leaps & Bounds Pediatric Therapy Inc. to use my name and likeness to promote the program, it's fiscal agent, and/or their activities.

_____ _____

Signature Date

_____

Printed Name of Parent/Guardian

_____

Printed Name of Patient

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LEAPS & BOUNDS
PEDIATRIC THERAPY

Timeliness

We value your time and don't want to keep you waiting. Occasionally we are delayed an unexpected event with another patient but be assured that the quality of your time with the therapist will not suffer. If you arrive late, your treatment will end at the scheduled time in order to be respectful of the next patient's time. Regular treatment time will end after 50 minutes to allow for time to discuss progress with the therapist, and also to insure the therapist has ample time to properly disinfect the area and tools for the next patient. If your appointment is scheduled for 30 minutes, your treatment time will end after 25 minutes.

No Shows/Cancellations

It is important to keep any appointments you schedule or contact us if you cannot. This way we can schedule others who wish to receive treatment. We require 24 hours notice if you have to cancel or reschedule your appointment. If the cancellation is less than 24 hours notice, you be charged $50.00 for the no-show fee. If you fail to attend two appointments consecutively without notifying the front office, your child will be removed from the schedule. If there is a history of cancellations, you may be removed from the schedule in order to accommodate regular attending patients.

We understand that your child may wake up sick, and we would rather you not bring your child into therapy sick, to avoid exposing other children, our staff, and to be sure your child is able to participate fully. We ask that you call as soon as possible, the night before, or as soon as you realize they may be ill. Under these circumstances, we can waive the one time late cancellation fee.

If you are more than 15 minutes late to your ranch session, the remainder of your time will most likely not be on the horse, but will be with the therapist working on functional activities. The horses, horse handling staff, and volunteers are scheduled according to the patient schedule in blocks and need to have scheduled breaks, which is why they may not stray from their schedule.

Should Leaps & Bounds need to cancel hippotherapy for weather reason, your appointment will be in the clinic. Your child comes to us to receive physical/occupational/ or speech therapy. Most times we are able to use the horse per the treatment plan, but at times we may not be able to and they will receive physical/occupational/ speech therapies in our clinic setting. You will be notified of weather cancellations a minimum of 2 hours prior to treatment session, when possible. If you choose not to come to your scheduled sessions because the horses are unavailable, you will be charged the $50 cancellation fee.

There is a lot of preparation that goes into our ranch session. Scheduling around maintenance and deliveries, horse well care/ill care/ maintenance, as well as physical exercise and preparation of the

horse earlier in the week or the morning of sessions. Our barn management team works hard to keep our horses scheduled appropriately around a legally mandated number of working hours and staff and our volunteer dedicate their time to helping keep these horses ready to provide excellent therapy. Please keep this in mind with scheduling and providing ample notice to cancel.

Billing Information

We will verify your insurance benefits prior to your appointment and you will be notified of copayment or coinsurance that will be due at each visit. If a deductible applies, we will provide you with that information and the full payment will be due at each visit until your insurance company has provided us with the information that your deductible has been met. You will receive an EOB (Explanation of Benefits) form your insurance company detailing when they have made a payment to us. You will not receive monthly statements, your payment is due at each date of service.

Your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. We ask that you verify your benefits with your insurance company as well, to be sure we were provided with accurate information. *It is ultimately your responsibility to appeal if an insurance company has denied payment and to provide the insurance company with necessary or requested information.*

If after 90 days no arrangements have been made for payment, your account may be placed with a collections agency, and the patient's services will be terminated immediately.

Patient Consent and Release

I understand that I am financially responsible for all charges for services rendered regardless of litigation, or insurance reimbursement. I understand that the parent accompanying a minor will be responsible for payment.

I authorize Leaps & Bounds Pediatric Therapy Inc. to release any necessary information to my insurance carrier and authorize payment directly to Leaps & Bounds Pediatric Therapy Inc. for any therapy benefits available under my insurance plan. I have read and understand the billing and attendance information above.

I have read the above information and acknowledge the above conditions.

Parent/Guardian Signature_____