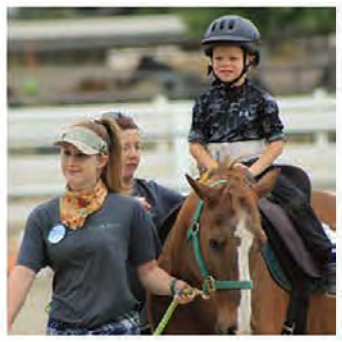
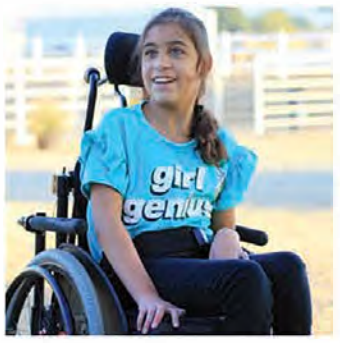
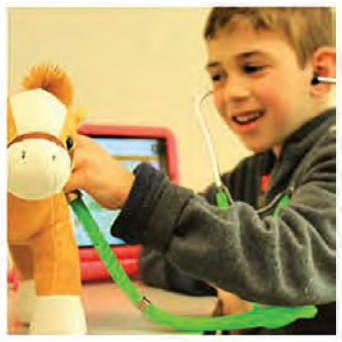
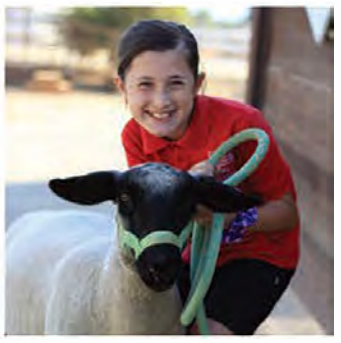
Welcome to the Leaps & Bounds Pediatric Therapy Family!

We are honored that you have chosen us to help yourself or your child grow by leaps and bounds. At Leaps, we are a dedicated and passionate group of people, and our mission is to provide excellent care, and the whole family is at the center of our mission.

We take pride in caring for the whole family, which is why you will often hear us refer to our "Leaps Family." We work in partnership with Friends of Leaps & Bounds, a 501c3 nonprofit organization, to support the delivery of excellent therapy services. **That is right- your child's care is supported by fundraising- not just when we use the horse as a tool, but every single visit!** We rely heavily on our supporters, from community members, patient families, local businesses, and grant programs to help us keep specialty care accessible in our community...for YOU! Not only does Friends of Leaps support therapy service, but really has enabled us to take care of the whole family with our free monthly Parent Group meeting, Sibling Support Program, multiple fun family events throughout the year, and low cost recreational activities that support your family far beyond receiving physical, occupational, and speech therapy services.

There are no other centers in the state that accept insurance reimbursement for hippotherapy, and many community specialty pediatric practices are closing their doors, or moving to all cash pay model, due to the tiny margin. Late cancellations, and not showing for your therapy session significantly impact this already tiny margin, and not only impacts your child's progress, but our ability to serve all children in need.

Much like all children's healthcare centers, we have to raise funds to deliver specialty care and we want specialty care to continue to be accessible for YOU! And unlike many large charities, the funds we raise have a direct impact on supporting therapy, and aren't directed towards salaries and office expenses.

There are a lot of opportunities to engage with Friends of Leaps fundraising activities, and support each member of your family, so be sure to follow along on social media, check for email blasts, or chat with our team in person! Our fundraising efforts are fueled by the very families we serve, from rallying your circle to support our annual Saddle Up event, nominating Leaps for grants and awards, seeking donor support from your employer, or local companies to fund our cause, purchasing a brick in our Pave the Way campaign, using Amazon Smile, sharing our fundraisers throughout the year, to hosting your own fundraisers for Leaps, our families are simply awesome.

We ask that you always choose Leaps as your charity of choice when given the opportunity. We are in this together, and working together, we have created and continued support this awesome place, right in our own backyard!

FRIENDS OF LEAPS & BOUNDS

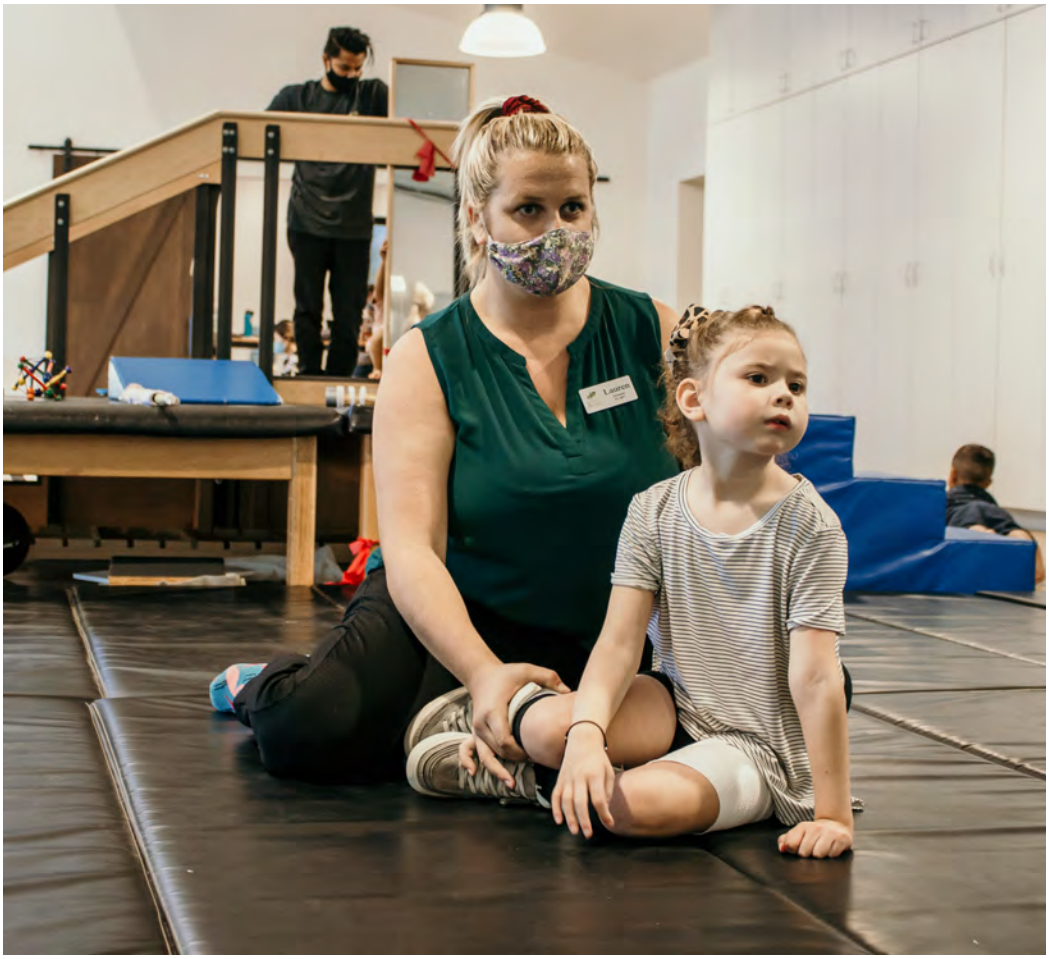
EVERY SINGLE SESSION OF THERAPY (ON, AND OFF THE HORSE) AND ADAPTIVE RIDING IS SUPPORTED BY FRIENDS OF LEAPS & BOUNDS.

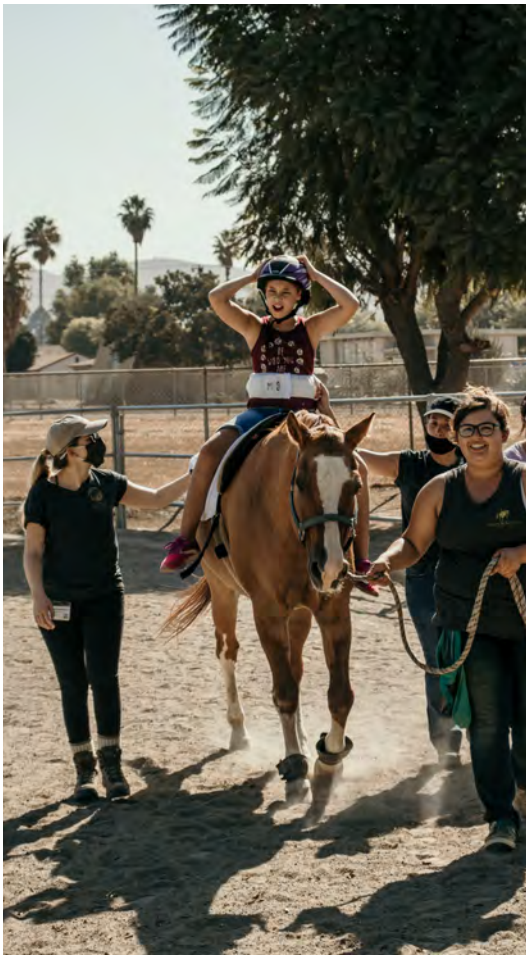
FRIENDS OF LEAPS & BOUNDS IS DRIVEN BY OUR PARENTS, AND COMMUNITY MEMBERS.
WE NEED YOUR HELP TO CONTINUE TO SERVE YOUR CHILD

Ways you can get involved with
Friends of Leaps & Bounds...

-Spring Gala- Saddle Up for Pediatric Therapy
-Fall Festival
-Dine-In Nights
-Corporate Sponsorships
-Employer Gift Matches
-Community Grant Opportunities
-Share on Instagram & Facebook

FRIENDS OF LEAPS & BOUNDS PEDIATRIC THERAPY INC IS A 501C3 NON PROFIT ORGANIZATION TIN 455413548





For questions about ways to get involved, contact us at ALadd@LeapsPediatric.org

Patient Intake Form

Patient Last Name: _____ First Name: _____ Middle I: _____

Current Address: _____

City: _____ State: _____ ZIP Code: _____

Date of Birth: _____/_____/_____ Ethnicity: ___ Caucasian ___ African-American ___ Hispanic/Latino

Gender: ____ M ____ F ___ Asian/Pacific Islander ___ Other/Unknown ___ decline to answer

Parent/Guardian Name: _____ Relationship to patient: _____

1st Phone #: _____ E-mail Address: _____

Parent/Guardian Name: _____ Relationship to patient: _____

2nd Phone #: _____ E-mail Address: _____

Additional Contact Name: _____ Relationship to patient: _____

3rd Phone #: _____

Can we send you emails regarding your child? _____ Yes _____ No

Best Contact Options: _____ Email _____ 1st Phone # _____ 2nd Phone # _____ 3rd Phone #

Primary Care Physician or Pediatrician: _____

Physician Address: _____

Phone #: _____ Fax #: _____

*How did you hear about us? ☐ Doctor Referral ☐ Website ☐ Friend Referral: _____

☐ Facebook ☐ Instagram ☐ Other source: _____

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

Your child's therapy session is made possible by
Friends of Leaps & Bounds Pediatric Therapy, 501c3 nonprofit organization

Child's Health History

Pregnancy and Birth History

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

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

If yes, please describe: _____

Child's Health History

Does your child have a medical diagnosis? _____ Yes _____ No

If yes, please describe: _____

Does your child have any allergies? _____ Yes _____ No

If yes, please describe: _____

Has your child had any hospitalizations? _____ Yes _____ No

If yes, please describe: _____

Has your child had any surgeries? _____ Yes _____ No

If yes, please describe: _____

Are your child's immunizations current? _____ Yes _____ No

Is your child taking any medication? _____ Yes _____ No If yes, please list:

What are your concerns about your child?

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

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Office Policy

Timeliness _____
(Initial)

We value your time and don't want to keep you waiting. Occasionally, we are delayed due to an unexpected event with another patient; but be assured that the quality of time with your therapist will not suffer. However, if you arrive late but within the first 15 minutes, your treatment will end at the scheduled time in order to be respectful of the next patient's time. If you arrive 15 minutes or later, your session will be rescheduled. Typically, approximately 5-10 minutes of your scheduled appointment time will be used for consult with your therapist and cleanup/set up time.

Late Cancellation / No-show – ZERO TOLERANCE POLICY _____
(Initial)

It is important to keep any appointments you schedule or contact us as soon as possible if you cannot - this way we can schedule others who wish to receive treatment. We require 24 hour notice if you have to cancel or reschedule your appointment.

- If you fail to attend two appointments consecutively without notifying the front office, your child will be removed from the re-occurring schedule and you will have the option to schedule with our flexible schedule.
- If there is more than one no-show and/or frequent cancellations, your child may be removed from the reoccurring schedule and asked to schedule with our flexible schedule.
- If your child will be absent from their appointments for 2 consecutive weeks, your child may be removed from the schedule and you will be asked to call back to reschedule once they return from their break.
- We also now offer Teletherapy session for convenience & flexibility.

You/your child comes to us for Physical, Occupational and/or Speech Therapy services. Our therapist use a variety of treatment tools including; the horse, a ball, treadmill, weights, swing, putty, etc. Should they be unable to use one of these tools, your appointment will remain scheduled. If for any reason we need to cancel or re-schedule your session, you will be notified.

Illness _____
(Initial)

We understand that your child may wake up sick. We would rather you not bring your child into therapy sick to avoid exposing other children or our staff, and to be sure your child is able to participate fully. Also, if your child is too sick to attend school, they should not attend therapy. 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 late cancellation fee on the 1st occurrence. We ask all patients to wait at least 24 hours after breaking a fever, vomiting or diarrhea before returning to therapy. If your child is well enough, we have the option to see them @ their regular appointment time via Teletherapy.

Conflict or Concern Resolution _____
(Initial)

We hope you love it here. We hope you are happy with your care from the reception area through the treatment rooms and across our campus. But sometimes concerns arise and we want to make them right. Please share your concerns regarding evaluation and treatment directly with your therapist. Our therapists are your partners for success and are here to guide you as part of your child's care team. Our Clinical Director, Jennifer Landry, is available to help should your concerns still not be resolved after speaking with your therapist. She can be reached directly at jlandry@leapspediatric.org or by calling the main line (951) 340-0431 ext. 107.
Our welcome desk and billing staff are also here to help with any procedural issues, your comfort on our campus, or payment issues etc. Yesenia Cornejo, our Patient Care Coordinator or Ashley Beadel, our Administrative Director are available for all concerns that you feel still may not be resolved. Yesenia can be reached directly at ycornejo@leapspediatric.org and Ashley at ashley@leapspediatric.org or you can call the main line (951) 340-0431. (Continued on next page)

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And should your issues still not be resolved, please contact our director, Dr. Cassandra Sanders-Holly at our main number (951)340-0431 or cassandra@leapspediatric.org. We want you to be happy with your care, and feel supported as part of the Leaps Family. We want your child to succeed, and grow by leaps and bounds! It's important to us.

Billing Information _____
(Initial)

Copayments, coinsurance and any other applicable fees are due at the time of service.
The patient may be denied services if the fees due are not collected.

If payment is not received for services rendered to you/your child in a timely manner, you/your child will be removed from the schedule due to inability to pay patient responsibility and will not be able to resume services until the balance of the account is paid in full.

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service.

We strongly suggest you call your insurance and obtain benefit information for therapy services to avoid any coverage discrepancies. If there are any differences in regards to what has been communicated, please let us know immediately.

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

You will receive an EOB (Explanation of Benefits) or RA (Remittance Advice) from your insurance company detailing when they have made a payment to us as well as a breakdown for patient responsibility.

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 person 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: _____

Printed Name: _____

Date: _____

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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: _____ Date of Birth: _____/_____/_____

Authorizing communication regarding PHI with the following:

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

Parent/Guardian Signature: _____

Printed Name: _____

Date: _____

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Patient Photo Release Agreement

☐ **I decline** the use of my child's likeness, image, voice, and/or appearance in any way.

(Continue to bottom of form)

If you consent, please complete the following:

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 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, its fiscal agent, and/or their activities.

Parent/Guardian Signature: _____

Printed Name: _____

Printed Name of Patient: _____

Date: _____

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Release of Liability

This release of liability made and entered into on _____, by and between Leaps & Bounds
DATE
Pediatric Therapy, INC., and _____. In return for the use, today and on all
PARENT/GUARDIAN NAME
future dates, of the horses, services, facilities and property of Leaps & Bounds Pediatric Therapy INC, the rider/patient, his or her parents/guardians, his or hers legal representatives hereby expressly agree the following terms and conditions:

- Rider/patient and parents/guardian has been advised that ASTM safety approved riding helmets with chin harness is required any time a person is mounted.
- Rider/patient and parents/guardian understands that hippotherapy services require a licensed physical therapist/physical therapist assistant and occupational therapist/occupational therapist assistant be present during the session.
- Rider/patient and parents/guardian agree to assume all responsibility and risks of injury, death, or property damage from the participation in equestrian activities. Further they agree to hold Leaps & Bounds, its officers, directors, employees, subcontractors, and volunteers free from liability or damages for any injury to person(s) or property damage or loss as a result of this participation.
- Rider/patient and parents/guardian and Leaps & Bounds acknowledge and agree that riding is a dangerous sport and horses are extremely unpredictable and dangerous by nature even if well train and handled properly.
- It is further agreed by all concerned and involved that every effort is always taken to protect horse and rider/patient from any danger that can be identified.

Rider/Patient: _____

Age: _____ Date of Birth: _____/_____/_____

Address: _____

Home Phone: _____ Cell Phone: _____

_____
Parent/ Guardian Name (Print)

_____ _____
Parent/Guardian Signature Date

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