# NOTICE OF PRIVACY PRACTICES
# FOR
# Horizon Pediatric Consultants, LLC/Rocking Horse Rehab

**THIS NOTICE DESCRIBES HOW TREATMENT INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**If you have any questions about this Notice, please contact our Privacy Officer, Sheri Marino at (973) 731-8588**

**This Notice of Privacy Practices is effective August 1, 2004**

## Our Duty to Protect Your Health Information:

We are required by law to protect the privacy of your health information including the health information that can be used to individually identify you. This information is known as "Protected Health Information," or "PHI" and includes health information about your past, present or future health or condition. We use this PHI to create a record of the health care services we provide to you, to obtain payment for the health care services we provide to you and to perform other operational or administrative types of functions in connection with the health care services we provide for you.

We understand your health information is extremely personal and we understand we have a legal duty to protect your PHI. We are required to extend certain privacy protections to you and to give you this Notice of Privacy Practices so that you understand how, when and why we may use or disclose your PHI both with and without your authorization. We are required by law to abide by the terms of this Notice of Privacy Practices. We are also required to inform you of your rights to access and control your PHI. This Notice of Privacy Practices extends to all of the PHI we collect and maintain about you. Please note that we reserve the right to change the terms of this Notice of Privacy Practices. If we do make a change to this Notice of Privacy Practices, we will post the revised Notice of Privacy Practices in our office. Upon your request, we will also provide you with a copy of any revised Notice of Privacy Practices.

## A. We may use and disclose PHI about you without your authorization to provide HEALTH CARE TREATMENT to you:

We may use and disclose PHI about you without your authorization to provide health care treatment to you. This may include communicating with our staff members or other health care providers regarding the treatment and health care services we provide to you. For example, we may use and disclose PHI about you when you need a prescription, an x-ray, laboratory work or other types of health care services. Also, we may use and disclose PHI about you when we refer you to another health care provider. For example, if we refer you to a doctor, this doctor will need to know the results of previous laboratory work or medical tests so this doctor will have complete information about your medical condition and treatment.

## B. We may use and disclose PHI about you without your authorization to obtain PAYMENT for the services we provide to you:

We may use and disclose PHI about you without your authorization to obtain payment for the services we provide to you. When we bill and collect payment for the services we provide to you, PHI needs to be shared with those responsible for paying for your services. This includes sharing PHI about you to your health insurance companies, Medicare, Medicaid and any other third party payor involved in the payment of your health care. Many times, to bill and collect for the services we provide to you, we need to share your PHI with health plan billing departments, collection departments and agencies and consumer reporting agencies (for example, credit bureaus). For example, after a treatment session, we may need to share information with your health plan about the nature of your visit, a diagnosis and the services we provided to you so that we can be paid or you can be reimbursed for these services. Other times, we may need to tell your health plan about a treatment you are going to receive to obtain prior approval for the treatment or to determine whether your health plan will pay for this treatment.

**C. <u>We may use and disclose PHI about you without your authorization for HEALTH CARE OPERATIONS in connection with the services we provide to you:</u>**

We may use and disclose PHI about you without your authorization for health care operations in connection with the services we provide to you. Operating a therapy office involves many business type activities and at times, it is necessary to use and disclose your PHI for these "health care operations" to help improve the quality of the care we provide to you, to increase the efficiency of our office and to reduce health care costs. Some examples of the ways we might use and disclose PHI about you for these health care operations include using PHI about you to help us develop ways to assist our office and staff in deciding what treatments should be provided to others, cooperating with outside organizations including government agencies and accrediting bodies that assess the quality of the care we provide, cooperating with outside organizations that evaluate, certify or license health care providers, staff or facilities, assisting various people such as accountants and lawyers who review our activities and help us comply with the law, conducting business management and general administrative activities related to our office and resolving grievances with our office.

**D. <u>We may contact you to provide you with appointment reminders:</u>**

We may use and disclose PHI about you to contact you and provide you with a reminder about an appointment you have with our office.

**E. <u>We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you:</u>**

From time to time, we may use and disclose PHI about you to tell you about possible treatment alternatives or options that may be of interest to you. We may also, from time to time, use and disclose PHI about you to tell you about various health-related benefits or services that may be of interest to you. For example, if you are diagnosed with a particular condition, we may tell you about other therapy services that may be of interest to you.

**F. <u>You have the right to object to certain uses and disclosures:</u>**

Unless you notify our Privacy Officer listed on the cover page of this Notice of your objection to or restrictions on these uses and disclosures, we may use and disclose PHI about you in the following circumstances:

- **<u>Others directly involved in your healthcare:</u>** We may share PHI about you to a family member, a relative, a friend or any other person identified by you if this person is directly involved in your care, including payment for your care. If you are incapable or unavailable to object to this sharing of PHI about you, then we may use and disclose PHI about you to this person if, in our professional judgment, this use and disclosure is in your best interest.

- **<u>Disaster relief purposes:</u>** We may use and disclose PHI about you to an authorized public or private disaster relief agency (for example, the American Red Cross) to assist in disaster relief efforts so that your family can be notified about your condition, status and location.

**G. <u>We are required and/or permitted to use and disclose PHI about you without your authorization under certain circumstances:</u>**

The law provides that under certain circumstances, we are either required or permitted to use and disclose PHI about you without your authorization and without an opportunity for you to object. These circumstances include the following:

- **<u>As required by law:</u>** We may use and disclose PHI about you when a Federal, state or local law requires us to do so. This use and disclosure will be in compliance with the relevant law. For example, we must disclose PHI about you to government authorities that monitor compliance with these privacy requirements.

- **<u>For public health activities:</u>** We may use and disclose PHI about you to assist in public health activities. For example, we may use and disclose PHI we collect about you if you have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition. This PHI will be disclosed to a public health agency responsible for collecting this type of information.

- **<u>For cases of abuse, neglect or domestic violence:</u>** We may use and disclose PHI about you that relates to cases of abuse, neglect or domestic violence. This PHI about you can be used and disclosed to a law enforcement agency or other government authority.

- **<u>For health oversight activities:</u>** We may use and disclose PHI about you to health oversight agencies that are authorized to conduct audits, investigations and inspections of health care programs and other activities. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws. For example, we may use and disclose PHI about you to Medicaid programs to conduct audits of our billing practices.

- **<u>For judicial and administrative proceedings:</u>** We may use and disclose PHI about you for use in any judicial or administrative proceedings. For example, if you are involved in a lawsuit, we may disclose PHI about you in response to a court order such as a subpoena, but only if reasonable efforts have been made to tell you about this request or to obtain an order protecting the information requested.

- **<u>For law enforcement purposes:</u>** We may use and disclose PHI about you for certain law enforcement purposes. For example, we may use and disclose PHI about you in response to a court order, a subpoena, a warrant or a summons. Additionally, we may use and disclose PHI about you to identify or locate

a suspect or fugitive, to identify a victim of a crime in limited circumstances, to provide information about a death that may be the result of criminal conduct, to provide information about criminal conduct at this office and to provide information in emergency circumstances to report a crime, the location of a crime or the identity, description or location of the person who committed the crime.

- **For coroners, medical examiners and funeral directors:** We may use and disclose information about you to a coroner or medical examiner. For example, this may be necessary to identify you upon your death or to determine the cause of your death. We may also use and disclose information about you to funeral directors as necessary to carry out their duties.

- **For organ, eye or tissue donations or transplants:** We may use and disclose PHI about you to organizations that handle organ procurement and eye and tissue banks if you are an organ donor. This is to help these organizations and banks locate and assist in the organ or tissue donation and transplant process.

- **For research purposes:** We may use and disclose PHI about you for medical research purposes. For example, a research project may involve comparing the results of all patients who used one type of to the results of all patients who used another medication for the same condition.

- **To avert a serious threat to health or safety:** We may use and disclose PHI about you to prevent a serious threat to your health and safety or the health and safety of the public. However any use and disclosure for this purpose would only be to someone who is able to help prevent the threat.

- **For specific government functions:** We may use and disclose PHI about you as this relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President and medical suitability or other determinations to be made by the Department of State.

- **For correctional institutions:** We may use and disclose PHI about you if you are an inmate of a correctional institution or under the custody of a law enforcement official. For example, we may use and disclose PHI about you if this is necessary for the institution to provide you with health care services, to protect your health and safety or the health and safety of other inmates or to protect the health and safety of employees at the institution.

- **For workers' compensation:** We may use and disclose PHI about you for workers' compensation or other similar programs. For example, if necessary to comply with programs that provide benefits for work-related injuries or illness, we may use and disclose PHI about you.

***** ANY OTHER USES OR DISCLOSURES OF PHI ABOUT YOU REQUIRES YOUR SPECIFIC WRITTEN AUTHORIZATION *****

Except for the circumstances listed above, any other uses or discloses of PHI about you requires that we obtain from you a specific written authorization to release PHI about you. If you sign a written authorization allowing us to use or disclose PHI about you for a specific purpose, you have the right to cancel this authorization at a later time. You must cancel your authorization by notifying our Privacy Officer in writing. If you cancel your authorization in writing, we will not use or disclose PHI about you after we receive this cancellation except for disclosures which were being processed before we received your cancellation.

## *** YOU HAVE CERTAIN RIGHTS REGARDING THE USE AND DISCLOSURE OF PHI ABOUT YOU ***

Under the law, you have certain rights regarding the use and disclosure of PHI about you. Your PHI privacy rights include the following:

**H. <u>You have the right to request restrictions on uses and disclosures of PHI about you:</u>**

You have the right to request restrictions on the uses and disclosures of PHI about you for treatment, payment or health care operations. We will consider your request, but please note that we are not legally required to agree with the restriction. To the extent that we do agree to any restrictions on our use and disclosure of PHI about you, we will put this agreement in writing. Please note, however, if necessary in an emergency treatment situation, we are permitted to use and disclosure PHI about you. Also, we cannot agree to limit our uses and disclosures of PHI about you that are required by law. If you want to request a restriction, you must notify our Privacy Officer, in writing and tell us what information you want to limit.

**I. <u>You have the right to request alternative methods to communicate with you:</u>**

You have the right to request an alternative method to communicate with you. This includes the right to request how and where we contact you about your PHI. For example, you may request that we contact you at your work address or phone number instead of your home address or phone number or that all communications be in writing rather than by telephone. We must accommodate all <u>reasonable</u> requests, but when appropriate, we may condition your request on you providing us with information regarding how payment, if any, will be handled. To request an alternative method of communication, you must notify our Privacy Officer, in writing. This written request must include that alternative address, telephone number or other method of contact you request. We will not ask you for the reason for your request.

**J. <u>You have the right to inspect and copy PHI about you:</u>**

You have the right to inspect and copy the records that contain PHI about you. If you would like to inspect and receive a copy of PHI about you, you must notify our Privacy Officer, in writing and tell us the information you would like to inspect and copy. We have the right to charge you reasonable fees related to the copying of records. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to this format and to the costs for such a summary or explanation. We will respond to your request within thirty (30) days. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we cannot grant your request and we will describe any rights you may have to request a review of our denial. Please note that this request usually applies to treatment and billing records, but does not include psychotherapy notes.

**K. <u>You have the right to request an amendment of PHI about you.</u>**

You have the right to make amendments to treatment, billing and other records about you if you believe there is a mistake and the information in such records is incorrect or inaccurate. To request an amendment, you must notify our Privacy Officer, in writing. This written request must explain your reason for the requested

amendment(s). We may deny your request for an amendment if: (1) the information in the record was not created by us, unless the person or entity who created the information is no longer available to amend the record; (2) the information is not part of the record used to make decisions about you; (3) the information is not part of the information which you would be permitted to inspect and copy as provided for in Part J; and, (4) we believe the information is accurate and complete. We will respond to your request within sixty (60) days. If we deny your request to an amendment of PHI about you, we will tell you in writing the reasons for the denial and describe your right to give us a written statement disagreeing with the denial. If we accept your request to amend the PHI about you, we make the correction and will make reasonable efforts to inform others of the amendment.

**L. <u>You have the right to an accounting of the disclosures we have made of PHI about you:</u>**

You have a right to request a list of certain disclosure we have made of PHI about you. You may ask for disclosures made up to six (6) years before your request (not including disclosures made prior to April 14, 2003). If you would like a list of the disclosures we have made of PHI about you, please notify our Privacy Officer, in writing. We will respond to your written request within sixty (60) days. The first list of disclosures you request within a twelve (12) month period will be free. For additional requests within a twelve (12) month period, we will charge you for the costs of providing the lists. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time before any costs are incurred. Please note that we are not required to account for disclosures made under the following circumstances: (1) for your treatment; (2) for billing and collecting for your treatment; (3) for our health care operations; (4) for disclosures requested or authorized by you or disclosures made to individuals involved in your health care; (5) for facility directory information; (6) for disclosure permitted by law when the use and disclosure relates to certain specialized government functions or relates to correctional institutions or other law enforcement custodial situations; (7) for disclosures that are part of a limited data set that does not contain certain information that would identify you; and, (8) for disclosures that were made before April 14, 2003. If we provide you with a list of disclosures, it will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed and the purpose of the disclosure.

**M. <u>You have the right to receive a paper copy of this Notice of Privacy Practices:</u>**

You have the right to request a paper copy of this Notice of Privacy Practices at any time by requesting a copy form our Privacy Officer. We will provide you with a copy of this Notice no later than the date you first receive service from us.

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***** YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES *****

If you believe your privacy rights have been violated by us and you would like to file a complaint with us about our privacy practices, please contact in writing the person listed below:

Sheri Marino, Privacy Officer
Horizon Pediatric Consultants, LLC/Rocking Horse Rehab
12-22 Woodland Avenue
West Orange, NJ 07052

(973) 731-8588

You may also file a written complaint with the Secretary of the Department of Health and Human Services.

**If you file a complaint, we will not take any action against you or change our treatment of you in any way.**

# <u>Equine Assisted Activities Eligibility Guidelines</u>

**Rocking Horse Rehab makes every effort to accommodate all individuals who apply for our Equine Assisted Therapy programs. For the safety of our clients, horses, volunteers, and staff, we would like you to be aware of the following guidelines.**

**<u>Registration:</u>** All potential clients must return a completed registration packet. Once the registration forms are received by RHR, an evaluation may be scheduled.
**<u>Age Restriction:</u>** 2 years-adult (some exceptions may apply)
**<u>Weight Limit:</u>** Our current weight limit is 175lbs if ambulatory, 140lbs if the individual requires assisted ambulation, and 100 lbs if the individual is non-ambulatory.
**<u>Physician's Statement:</u>** Every client must obtain a signed, dated, and stamped physician's statement on an annual basis indicating that the individual is medically stable to participate in mounted equine assisted therapies. A signed physician's statement is required to resume mounted activities following any surgical procedure. Prescriptions are required for speech, physical, and occupational therapy.
**<u>Behavior:</u>** Equine assisted therapies may be contraindicated for clients presenting with behavioral disorders (including but not limited to aggressive behaviors, self-injurious behaviors, and self-stimulatory behaviors) which could create a dangerous situation for themselves, others, or for the horses.

**<u>Medical Conditions:</u> Precautions and/or contraindications for equine assisted therapies are listed on the reverse side of this document . Precautions and/or contraindications may determine client eligibility at the discretion of the treating therapist and Rocking Horse Rehab staff. If it is determined that the risk of equine movement or equine therapy in general outweighs the benefits, RHR maintains the right to determine an individual ineligible for services. If any medical or behavioral conditions develop during the course of treatment, or if a therapist determines they are uncomfortable handling or treating a specific condition, RHR reserves the right to discharge a client at their discretion. Please see the back of this form for a comprehensive list of contraindications and precautions for equine assisted therapies.**

**Thank you for understanding these guidelines. Our goal is to provide the safest Equine Assisted Therapy program that is also beneficial, enjoyable, and safe for all participants. If you have any questions or concerns, please feel free to contact us.**

**I have read and understand the equine assisted therapy guidelines and understand that all therapies are offered at the discretion of the treating therapist and RHR staff.**

**Parent/Guardian Name:** ____________________________________________________________________

**Sign:** ______________________________________________________________________________

10/2017

## Precautions and Contraindications

### Absolute Contraindications for Hippotherapy

- Acute mental health disorders that would be unsafe (e.g., fire-setting, suicidal, animal abuse, violent behavior)
- Acute herniated disc with or without nerve root compression
- Chiari II malformation with neurologic symptoms
- Atlantoaxial instability, a displacement of the C1 vertebra in relation to the C2 vertebra as seen on x-ray or computed tomography of significant amount (generally agreed to be greater than 4 mm for a child), with or without neurologic signs as assessed by a qualified physician; this condition is seen in diagnoses with ligamentous laxity such as Down Syndrome or juvenile rheumatoid arthritis.
- Coxa arthrosis, a degeneration of the hip joint; the femoral head is flattened and functions like a hinge joint versus a ball and socket joint. Sitting on a horse puts extreme stress on this joint.
- Grand mal seizures uncontrolled by medications
- Hemophilia with recent history of bleeding episodes
- Indwelling urethral catheters
- Medical conditions during acute exacerbations (e.g., rheumatoid arthritis, herniated nucleus pulposus, multiple sclerosis, diabetes)
- Open wounds over a weight-bearing surface
- Pathologic fractures without successful treatment of the underlying pathology (e.g., severe osteoporosis, osteogenesis imperfecta, bone tumor)
- Tethered cord with symptoms
- Unstable spine or joints including unstable internal hardware

### Precautions/Considerations for Patient Selection

- Age (minimum age is 2)
- Cognitive ability
- Sitting balance
- Poor head control/inability to wear a helmet
- Spasticity
- Height and weight
- Mobility and alignment
- Muscle stiffness
- Joint stiffness
- Limited mobility and/or malalignment
- Fear or anxiety
- Environmental considerations
- Cranial deficits
- Hetertropic ossification/myositis ossificans
- Osteoporosis
- Joint subluxation/dislocation
- Spinal fusion/fixation
- Spinal instability/abnormalities
- Hydrocephalus/shunt
- Seizure disorder
- Spina bifida
- Medications
- Poor endurance
- Skin breakdown
- Allergies
- Blood pressure control
- Physical/sexual/emotional abuse
- Exacerbations of medical conditions
- Migraines
- Medical instability
- Thought control disorders
- Weight control disorders
- Respiratory compromise
- Heart conditions
- Recent surgeries
- Substance abuse
- PVD

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# Application and Health History

**Background Information** Today's Date: ____/____/___

Client's Name: ______________________________DOB: _____/______/_____ Gender: ___M____F

Age: ____years ____months Height: ________ Weight:________ Hand Preference: ____L____R

Mother's Name: ____________________________ Father's Name: _______________________________

Address: ________________________________________________________________________________

Phone Number: ____________________________ Fax Number: ________________________________

Mother's Cell Phone:_________________________ Father's Cell Phone:___________________________

Email Address:___________________________________________________________________________

Mother's Occupation: _________________________Work No.: __________________________________

Father's Occupation: __________________________Work No.: ___________________________________

Siblings: ___________________________________ Age: ___________
___________________________________ Age: ___________
___________________________________ Age: ___________

Referral Source: ____________________________Language Spoken: _____________________________

**Primary Medical Diagnosis**: ______________________________________________________________

**Secondary Medical Diagnosis**: ____________________________________________________________

**Precautions:** ____________________________________________________________________________

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**Insurance Information**

Insurance Company: _________________________Patient ID #: ________________________________

Phone #: _____________________ Address: ________________________________________________

**Birth History**

Prenatal care began: _________________

Please describe any illness, accidents, or problems relating to the mother or child during and/or after pregnancy.

______________________________________________________________________________________

______________________________________________________________________________________

Medication's taken during pregnancy:

______________________________________________________________________________________

Tests during pregnancy:

Ultrasound: _______ Amniocentesis: _________ Stress tests: ________Other: _________________

Place of Birth: _____________Weeks Gestation: ____ Type of Delivery: ______ Length of Labor: _____

**Neonatal Period**

Birth Weight: ________ Apgar Score: _____________

Special Treatment in the delivery room: Intubated ( ) Oxygen ( ) Resuscitated ( ) IV placed ( )

Length of Stay and treatments received for both mom and child:

______________________________________________________________________________________

Since birth, please give dates and description of any hospitalizations, accidents, illnesses or health concerns:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Please list any medications your child takes on a regular basis:

Medication Purpose Times Amount

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

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**Medical Practitioner's Information:** Please include names and phone numbers.

Pediatrician: ____________________________________ Phone______________________

Hearing: ____________________________________ Phone______________________

Vision: ____________________________________ Phone______________________

Neuro: ____________________________________ Phone ______________________

Ortho: ____________________________________ Phone ______________________

Gastro: ____________________________________Phone: ____________________

**Education**

School Placement ___________________________ Phone No.: _________________________________

Teacher's Name ___________________________ Phone No.: _________________________________

School Schedule:
_____________________________________________________________________________________

**Therapy Services**

PT _________________________ Facility: _________________________ Phone No.: ___________

Frequency & Duration: _______________________________________________________________

OT_________________________ Facility: _________________________ Phone No.: ____________

Frequency & Duration: _______________________________________________________________

SLP _________________________ Facility: _________________________ Phone No.: ____________

Frequency & Duration: _______________________________________________________________

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Home Program Information (if applicable):

Home Program Coordinator: ______________________________ Phone No.: ______________________
Home Program Tutor: ___________________________________ Phone No.: ______________________
___________________________________ Phone No.: ______________________
___________________________________ Phone No.: ______________________
Total Hours Weekly: ___________________________________

**Reason for Referral**

| | | | | |
|---|---|---|---|---|
| Oral Motor______ | Language ______ | Behavior ______ | Vision ______ | Sensory ____ |
| Feeding ________ | Apraxia _______ | Cognitive _____ | Gross Motor _____ | Attention___ |
| Articulation ______ | Hearing ________ | Social _______ | Fine Motor ______ | Other: _____ |

Please describe the area of concern indicating when it was first noticed, and it's development.
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Current Skills**

Please describe your child's…..

Eye contact
______________________________________________________________________________

Gestures
______________________________________________________________________________

Speech Sounds
______________________________________________________________________________

Words
______________________________________________________________________________

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Sentences ______________________________

Behaviors ______________________________

Gross Motor Skills ______________________________

Fine Motor Skills ______________________________

Sensory Processing ______________________________

Hearing ______________________________

Vision ______________________________

Feeding Skills ______________________________

Respiration/Circulation ______________________________

Psycho/Social Function and Mental Health ______________________________

Allergies ______________________________

**Primary Concerns and Goals**

______________________________
______________________________
______________________________
______________________________

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**Weekdays and times available for treatment services**

______________________________________________________________________

Name of person completing this form: ________________________________________
Relationship: ______________________________________________________________
Signature: ________________________________________________________________
Date: ______________/_________/____________

*** Please provide copies of recent IEP, evaluations and/or progress reports.*

**PHOTO RELEASE**

I ___DO/___DO NOT consent to and authorize the use and reproduction by Horizon Pediatric Consultants, LLC, dba Rocking Horse Rehab of any and all photographs and any other audio/visual materials taken of my child for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature:__________________________________________________Date:_________________________
Parent or Legal Guardian

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# PHYSICIAN'S STATEMENT

Dear Doctor,

Your patient, ______________________________________________is interested in participating in equine assisted therapies and activities. In order to safely provide this service, our center requests that you complete the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contraindications to equine activities. Therefore, when completing this form, please note whether these conditions are present and to what degree.

<u>Orthopedic</u>
Atlantoaxial Instability-describe neurologic symptoms
Coxa Arthrosis
Cranial Deficits
Heterotropic Ossification/Myositis Ossificans
Joint Subluxation/dislocation
Osteoporosis
Pathologic Fractures
Spinal Fusion/Fixation
Spinal Instability/Abnormalities

<u>Neurologic</u>
Hydrocephalus/Shunt
Seizure
Spina Bifida/Chiari II Malformation/Tethered Cord/Hydromelia

<u>Other</u>
Age-under 4 years
Indwelling Catheters
Medications
Poor Endurance
Skin Breakdown

<u>Medical/Psychological</u>
Allergies
Animal Abuse
Physical/Sexual/Emotional Abuse
Blood Pressure Control
Dangerous to self or others
Exacerbations of medical conditions
Fire Settings
Heart Conditions
Hemophilia
Medical Instability
Migraines
PVD
Respiratory Compromise
Recent Surgeries
Substance Abuse
Thought Control Disorders
Weight Control Disorders

Thank you for your assistance. If you have any questions or concerns regarding this patient's participation in equine assisted therapies and activities, please feel free to contact the center at the address or phone number indicated above.

Sincerely,

Sheri A. Marino, MA, CCC-SLP
Executive Director

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# PHYSICIAN'S STATEMENT

*****PLEASE INCLUDE A PRESCRIPTION FOR PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPY. PRESCIPTION SHOULD READ, FOR EXAMPLE "PT/OT/SPEECH EVALUATION AND TREATMENT FOR UP TO 1 YEAR." PLEASE INCLUDE ICD 10 CODES FOR CONDITIONS TO BE TREATED. THANK YOU.**

Patient: ______________________________________DOB:____________Height:________Weight:________
Address: ____________________________________________________________________________________
Dianosis: ___________________________________________________Date of Onset: _____________________
Past/Prospective Surgeries: _____________________________________________________________________
Medications: ______________________________________________________________________________
Seizure Type: _____________________________________Controlled: Y N Date of Last Seizure: _________
Shunt Present: Y N Date of Last Revision: _________________________________
Special Precautions/Needs: ______________________________________________________________________
_____________________________________________________________________________________________
Mobility: Independent Ambulation: Y N Assisted Ambulation Y N Wheelchair Y N
Down Syndrome: Y N AtlantoDens Interval X-Rays, date: _______________ Result: + --
Neurologic symptoms of AtlantoAxial Instability: ____________________________________________________
Please indicate current past or special needs in the following systems/areas, including surgeries:

- Auditory: ___________________________________________________________________________
- Visual: _____________________________________________________________________________
- Sensory Processing: ___________________________________________________________________
- Speech: ____________________________________________________________________________
- Cardiac: ___________________________________________________________________________
- Circulatory: ________________________________________________________________________
- Integumentary/Skin: __________________________________________________________________
- Immunity: __________________________________________________________________________
- Pulmonary: _________________________________________________________________________
- Neurologic: _________________________________________________________________________
- Muscular: __________________________________________________________________________
- Balance: ___________________________________________________________________________
- Orthopedic: ________________________________________________________________________
- Allergies: __________________________________________________________________________
- Learning Disability: ___________________________________________________________________
- Cognition: _________________________________________________________________________
- Emotional/Psychological: ______________________________________________________________
- Pain: ______________________________________________________________________________
- Other: _____________________________________________________________________________

To my knowledge there is no medical reason why this patient cannot participate in equine assisted therapies and activities. However, I understand that Horizon Pediatric Consultants, LLC dba Rocking Horse Rehab will weigh the medical information above against the existing precautions and contraindications. I concur with a review of this patient's abilities and/or limitations by a licensed/credentialed health professional (e.g. physical therapist, occupational therapist, speech-language pathologist, etc.) in the implementation of an effective equine activity program.

Name/Title: ____________________________________________________MD DO NP PA Other: ____________________
Signature: ______________________________________________________ License/UPINNumber: ________________________
Address: _________________________________Phone: _______________________ Date:________________________________________

**PLEASE STAMP WITH THE PRACTICE ID**

# Rocking Horse Rehab

## Client On-Boarding Report

Please fill out the following in order for us to best help you. **Please also include a copy of both sides of your insurance card.**

Patient Name:__________________________________________________________________
Date of Birth:__________________________________________________________________
Address:______________________________________________________________________
Contact Tel #:__________________________________________________________________
Contact Email:_________________________________________________________________
Mother's Name:________________________________________________________________
Date of Birth:__________________________________________________________________
Father's Name:_________________________________________________________________
Date of Birth:__________________________________________________________________

Primary Insurance Carrier Name:__________________________________________________
Primary Insurance ID # and Group #:________________________________________________
Primary Insurance Member Tel # (found on back of ID Card):_________________________________
Primary Insurance Provider Tel # (found on back of ID Card):_________________________________
Claims Address (found on back of ID Card):___________________________________________
Website Address:______________________________________________________________
User Name :___________________________________________________________________
Password:_____________________________________________________________________

(If applicable)
Secondary Insurance Carrier Name:__________________________________________________
Secondary Insurance ID # and Group #:______________________________________________
Secondary Insurance Member Tel #:__________________________________________________
Secondary Insurance Provider Tel #:__________________________________________________
Claims Address:________________________________________________________________

Diagnosis Code(s):______________________________________________________________

## AUTHORIZATION FOR RELEASE OF INFORMATION

This will authorize Rocking Horse Rehab to submit health insurance claim forms on my behalf.

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The confidential information is specified below:

1. Contact information
2. Health Insurance Information
3. Claims and supporting documents ie notes/reports/evals etc.

The specific purpose for disclosure is as follows: Claims submission and insurance management

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The following information is provided to locate the requested records:

PATIENT'S NAME:

PATIENT'S ADDRESS:

DATE OF BIRTH:

A reproduction of this authorization form shall be considered as the original. I understand that by law, I do not have to release this information. However, I choose to do so voluntarily for the purpose specified above. I further understand that I may cancel this authorization for release of information at any time unless the information has already been sent. Permission to release the above information will expire in one year.

**NOTICE TO RECIPIENT OF INFORMATION**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2); the federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

____________________________________ ____________________________________

Patient's Signature (age 14 or older) Date

____________________________________ ____________________________________

Parent/Legal Guardian/or Authorized Representative Witness Signature

Rocking Horse Rehab
Horizon Pediatric Consultants, LLC
12-22 Woodland Ave.
West Orange, NJ 07052

Phone: 973-731-8588
Fax: 973-731-8520
www.rockinghorserehab.com

**ACKNOWLEDGEMENT OF RECEIPT OF THE
NOTICE OF PRIVACY PRACTICES
OF
HORIZON PEDIATRIC CONSULTANTS, LLC/ROCKING HORSE REHAB**

**Address:** ______________________ **Telephone No:**_____________

______________________

______________________

I hereby acknowledge that I have received from Horizon Pediatric Consultants, LLC/Rocking Horse Rehab a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Horizon Pediatric Consultants, LLC/Rocking Horse Rehab can use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact Sheri Haiken, Privacy Officer, if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Horizon Pediatric Consultants, LLC/Rocking Horse Rehab

______________________________________________ ______________

Signature of Patient or Patient's Parent/Legal Guardian Date

______________________________________________

Print Name of Patient or Patient's Parent/Legal Guardian