THERAPY ATTENDANCE POLICY

The primary focus of Dynamic Strides Therapy, Inc.'s ("DST") therapy program (the "Program") is to help the Patient named below to achieve his/her goals for therapy. We strive to maximize Patient's abilities, but regular therapy attendance is critical to achieving those goals and obtaining effective outcomes.

1. If Patient arrives more than 10 minutes late for his/her appointment, Patient may be rescheduled for a later date. A total of three (3) late arrivals to appointments in a one (1) month time frame will be considered excessive and may result in Patient's termination from the Program.

2. If Patient or Patient's representative does not call to inform DST that Patient cannot attend a scheduled appointment, the appointment will be deemed a "no-call, no show." Two consecutive no-call, no-shows may lead to Patient's termination from the Program. If Patient is unable to attend a regularly scheduled appointment, Patient or Patient's representative should call and cancel the appointment with at least **24 hours'** notice.

3. A cancellation rate of greater than **25%** over a three (3) month period will be considered excessive and may result in Patient's termination from the Program.

4. Patient will not be penalized for weather-related absences. However, a courtesy call is required if Patient will not be attending. If the clinic will be closed, a Program staff member will call and notify Patient or Patient's representative.

5. Extenuating and unforeseen circumstances will be addressed on an individual basis.

Patient Name: _____

Acknowledged and Agreed to by:

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date

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Fax: 417-627-5542

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_____ _____

Witness Date

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Patient Consent for Photographs and Interviews

I give my consent for Dynamic Strides Therapy, Inc. ("DST"), and/or its representatives or affiliates, to take and use photographs or films of me and/or interview me for publicity, educational, marketing, DST training, advertising and fundraising purposes through internal publication, external publication, radio, television, video or internet. *[I have crossed out any purposes or media formats I do not wish included.]* Such photographs, films and/or interview content will disclose the fact that I have been a patient of DST and may contain other information about me, including what I say in the interview, facts that can be inferred from the photograph or film, or personal health information that may be covered by the Health Insurance Portability and Accountability Act of 1996, its related regulations, and/or applicable state law.

- I understand that I am not required to sign this form in order to receive treatment or payment for my care.
- I understand that information used or disclosed under this authorization may be reused by the recipient and may no longer be protected by privacy regulations.
- I understand that I may revoke this authorization at any time by notifying DST in writing, and the revocation will be effective on the date notified (except to the extent action has already been taken based on my earlier consent).
- I understand that this authorization will expire in seventy-five (75) years, unless I have given written notification stating otherwise.
- I understand that neither I nor DST will receive direct or indirect payment for the communication related to this photo, film or interview.

My name….(check one):

- € May be used in connection with any photographs, videos, interviews, or other media formats I have approved above.
- € May not be used in connection with any photographs, videos, interviews, or other media formats I have approved above.

Patient Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Patient Signature: _____

Parent/Legal Guardian Name (if Patient is a minor): _____

Parent/Legal Guardian Relationship to Patient: _____

Parent/Legal Guardian Signature: _____

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PATIENT CONSENT AND RELEASE OF LIABILITY

I, for myself as the Patient named below or as the parent or legal guardian of the Patient named below, hereby consent to and assume the risk of participating in the hippotherapy program sponsored by DYNAMIC STRIDES THERAPY, INC. under the supervision of physical, occupational, and speech therapists, and/or any other therapeutic or recreational activities offered by DYNAMIC STRIDES THERAPY, INC. (collectively, the "Program").

I acknowledge my understanding that there are no assurances that Patient will receive physical or psychological benefits from participation in the Program and, if patient is participating in hippotherapy, that the ordinary risks associated with horseback riding may be increased by virtue of Patient's disability or medical condition. If patient is participating in hippotherapy, I further acknowledge and understand the inherent risks of equine activities and that horsemanship experiences can result in injury and even death.

For and in consideration of the agreement of DYNAMIC STRIDES THERAPY, INC. to provide Program services to Patient, I, for myself and/or Patient, and my/Patient's heirs and assigns, executors, or administrators, do hereby forever release, acquit, discharge and hold harmless DYNAMIC STRIDES THERAPY INC., its officers, directors, agents, employees, representatives and any therapists, volunteers and other people associated with the Program (the "Released Parties") and the successors and assigns of each Released Party from any liability associated with any personal injuries, physical or mental condition, known or unknown, to Patient, and the treatment thereof, as a result of, incidental to, or in any way arising from the acts or omissions of the Released Parties in connection with their provision of the Program services to Patient.

_____/_____/_____
Parent 1 or Legal Guardian (Print Name) Signature Date

_____/_____/_____
Parent 2 or Legal Guardian (Print Name) Signature Date

_____/_____/_____
Patient (Print Name) Signature (If over 18 years of age) Date

(In the event that you have sole legal custody of or are the sole living parent of the above-named child, only one signature is required.)

WARNING

Under Missouri law, an equine activity sponsor, an equine professional, a livestock activity sponsor, a livestock owner, a livestock facility, a livestock auction market, or any employee thereof is not liable for an injury to or the death of a participant in equine or livestock activities resulting from the inherent risks of equine or livestock activities pursuant to the Revised Statutes of Missouri.

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
EMERGENCY MEDICAL RELEASE FORM.

Covered Person's Name: _____ DOB: _____ AGE: _____

Covered Person is a: ____ DST Volunteer or ____ DST Patient (Check One)

Should a medical emergency arise, I understand reasonable efforts will be made to contact me prior to rendering treatment to the Covered Person, but that treatment will not be withheld if I cannot be reached.

I give my permission to Dynamic Strides Therapy, Inc. ("DST"), staff, employees, or designees to render first aid to the Covered Person should the need arise or to take the Covered Person to the emergency room of the nearest hospital. I hereby authorize the hospital's medical staff to provide treatment which a physician deems necessary for the well-being of the Covered Person. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. I understand that it is my responsibility for the payment of any and all expenses connected with the injury and/or illness that may not by covered by my insurance.

RELEASE AND HOLD HARMLESS: (A) Covered Person, for himself/herself; or (B) Parent(s)/Legal Guardians(s), on behalf of themselves the Covered Person, and, in the case of both (A) and (B), each of their respective heirs, further agree to and do hereby release and hold harmless Dynamic Strides Therapy, Inc. and its officers, directors, associates, employees, and agents from and against any and all liability, claims, damages, demands, causes of action, and judgments, including but not limited to those relating to personal injury and damage to or loss of property, (collectively "Claims") that arise from or relate to the administration of emergency medical services to the Covered Person. This release and hold harmless applies to claims on tort, negligence (including the negligence of Dynamic Strides Therapy, Inc.), privacy interests, and otherwise whether now known or that may arise in the future. This release and hold harmless does not apply to claims based on action or inaction by those otherwise released and held harmless that constitutes gross negligence or an intentional tort.

Furthermore, I agree to indemnify Dynamic Strides Therapy, Inc. and its officers, directors, associates, employees, and agents from any suit, claim or action brought by the Covered Person, the Covered Person's other parent and/or legal guardian (if any), and any other person related to the Covered Person in connection with this matter.

A copy of this consent shall serve the same purposes and have the same force, effect and authority as an original. I declare that I have completely read and fully understand the information contained in this authorization form and voluntarily accept the terms and conditions. By my signature below, I declare that I am the Covered Person or the parent/legal guardian of the Covered Person authorized to sign this form and give permission for emergency medical treatment on behalf of the Covered Person.

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Covered Person (Signature): _____ Date: _____

If Covered Person is a minor, Parent/Legal guardian Name (Print) _____

If Covered Person is a minor, Parent/Legal guardian (Signature): _____ Date: _____

Signatory's Home Phone Number: _____ Cell: _____

Signatory's Home Address: _____

City State Zip

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Patient Insurance Information: (please fill out form completely)

Patient name _____ Date_____

Address: _____
PO Box/Street City State Zip Code

Sex: M F Date of Birth: _____/_____/_____ SSN: _____-_____-_____

Referring Physician: _____Primary Care Physician_____

Responsible Party: Name: _____Date of Birth: ___/___/___ SSN: ____-____-____

Address: _____ Relationship: _____
PO Box/Street City State Zip Code

Home phone_____ Cell phone _____ Email_____

Employer: _____ Work phone _____

Address_____
PO Box/Street City State Zip Code

Emergency Contact: Name _____

Relationship_____ DOB ____/____/_____ Phone_____

Insured's Information:

Primary Insurance Company: _____ Name of Policy Holder: _____

Address: _____
PO Box/Street City State Zip Code County

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Relationship to Patient _____

Secondary Insurance Company: _____ Name of Policy Holder: _____

Address: _____
PO Box/Street City State Zip Code County

Date of Birth: _____/_____/_____ SSN: ____-____-_____ Relationship to Patient_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I verify that all information above is correct to the best of my knowledge. I authorize Dynamic Strides Therapy, Inc. and any individual therapists employed or contracted by Dynamic Strides Therapy, Inc. who furnish services to the above-named patient to release any medical information necessary to process claims associated with the above-named patient. I allow a copy of this authorization to be used in place of the original.

I assign to Dynamic Strides Therapy, Inc. and any individual therapists employed or contracted by Dynamic Strides Therapy, Inc. who furnish services to the above-named patient the right to bill for the services the above-named patient has received from Dynamic Strides Therapy, Inc., the right to receive payment for the same, and the right to pursue payment for the same, including, but not limited to the right to pursue administrative appeals, litigation, and/or other relevant causes of action in connection with the same.

_____ _____

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Responsible Party's Signature Date

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Fax: 417-627-5542

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Patient's Medical History

(To be completed by Patient or Patient's guardian)

Please return prior to scheduling the evaluation:

- **Fax: 417-627-5542**
- **Email: kim@dstherapy.org**
- **Mail: 2673 E. Sawyer Road Republic, MO 65738**
- **Hand Deliver**

Patient:_____DOB:_____HEIGHT_____WEIGHT_____
Address:_____
Patient Lives With: _____
Diagnosis:_____Date of onset:_____
Medications:_____
Seizure Type:_____ Controlled: Y N Date of Last Seizure_____
Shunt Present: Y N Date of last revision:_____
Special Precautions/Needs:_____
_____
Mobility: Independent Walking Y N Assisted Walking Y N Wheelchair Y N
Braces/Assistive Devices:_____
Complications during pregnancy and/or delivery of Patient:
_____

_____

Please list and date any surgeries the patient has had:_____

_____

_____

Please list any other health care professionals currently treating the patient: _____

_____

_____

School Attended: _____ Grade: _____

*If patient currently has an IEP, please bring most recent copy

Has the patient had previous or current therapy? Yes No *If yes, where:*_____

Type: Speech Occupational Physical Play

*If currently receiving therapy, please bring most recent evaluations/progress reports

Why are you seeking therapy services?_____

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Please indicate current or past difficulties in the following systems/areas:

	Y	N	COMMENTS
Hearing			
Vision			
Sensory Concerns			
Speech			
Cardiac			
Circulation			
Skin			
Immune System			
Lung			
Nervous System			
Muscular/Tone			
Balance			
Orthopedic			
Allergies (Including latex and animal)			
Learning Disability			
Cognition			
Emotional/Psychological			
Pain			
Feeding/Swallowing			
Other			

This form has been completed to the best of my knowledge:

_____/_____/_____

Patient's Parent or Legal Guardian (Print Name) Signature Date

_____/_____/_____

Patient (Print Name) Signature (If over 18 years of age) Date

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