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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.

_____ _____
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: donna@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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RELEASE OF LIABILITY AND ASSUMPTION OF RISK

IN CONSIDERATION OF services provided by Dynamic Strides Therapy, Inc. and the use of the riding arena, horses, sensory gym, grounds, and/or related facilities located in, on, or at 2673 E. Sawyer Rd., Republic, Missouri 65738 (referred to herein as the "Property"), which is owned by 156 Corner, LLC (referred to herein as the "Owner"), and presently leased by Dynamic Strides Therapy, Inc. (referred to herein as the "Lessee") the undersigned acknowledges and agrees as follows:

1. I will abide by all written policies and procedures, whether known or unknown to me, and all verbal policies and procedures regarding the Property grounds and activities, and as Parent/Guardian I acknowledge that my child(ren) will abide by all written policies and procedures, whether known or unknown to me, and all verbal policies and procedures regarding the Property grounds and activities;

2. I, on behalf of myself and, if applicable, as Parent/Guardian of my child(ren), acknowledge and agree that risks and dangers exist and are inherent with respect to horseback riding, being around horses, services provided by Lessee, and other activities on the Property. These risks include, but are not limited to, physical injuries, bodily injury, psychological injuries, death, and property damage;

3. I, on behalf of myself and, if applicable, as Parent/Guardian of my child(ren), understand and acknowledge that I am responsible for my actions and those of my children on the Property and agree, represent and warrant that I will use the utmost level of care and safety with respect to my use and presence at the Property including supervision, if applicable, of my children in the use thereof. I am responsible for my actions and those of my children on and around the Property and agree, represent and warrant that I will use the utmost level of care and safety with respect to my presence at the Property including supervision, if applicable, of my children in the use thereof. I further acknowledge that I am and will remain responsible for the supervision of my own child(ren) at the Property;

4. I, on behalf of myself and, if applicable, as Parent/Guardian of my child(ren), hereby assume all of the risks of using Property grounds and related facilities and services provided by Lessee, and I, on behalf of myself and my children if applicable, will hold harmless Owner and Lessee, and their respective representatives, owners, members, officers, shareholders, directors, employees, heirs, successors, and assigns and including all of its parent, subsidiary, and related companies from and against any and all liability, actions, demands, damages, expenses and costs (including, but not limited to, attorneys' fees, paralegal fees, expert fees, litigation expenses, and court costs), claims, lawsuits of any nature whatsoever, causes of action of any possible nature in respect of injury, death, loss or damage to myself, my child(ren) or property however caused as a result of or in any way relating to my activities, or my child(ren)'s activities, on the Property, around the Property, and in any way relating to my use, or my child(ren)'s use, of the Property and my use of the services provided by Lessee and my children's use of the services provided by Lessee;

5. If, despite the signing of this waiver, a lawsuit is brought against Owner and/or Lessee and/or their respective representatives, owners, members, officers, shareholders, directors, employees, heirs, successors, and/or assigns, and including all of Owner's and/or Lessee's parent, subsidiary, and related companies, successors and assigns, and any agent, tenant, or lessee, in relation to use of the

Property, I agree to pay, without contribution, any and all court costs, attorneys' fees, litigation expenses, expert witness fees and costs incurred by Owner and/or Lessee as a result of such litigation;

6. I also declare that neither I nor my child(ren), if applicable, are under the influence of any chemical substance including alcohol or drugs at the time of the signing of this release or at the time of use of the Property;

7. I agree that if any provision of this release is deemed unenforceable under applicable federal law or the laws of the State of Missouri, the unenforceable portion shall be deemed stricken from this release, and the remaining clauses shall remain in full force and effect;

8. I, on behalf of myself and as Parent/Guardian of my child(ren), fully understand that services provided by Lessee and activities at the Property involve an inherent level of risk of injury. My participation in these activities and my signing of this waiver are completely voluntary, and my child(ren)'s participation in these activities and my signing of this waiver as Parent/Guardian of my/our child(ren) is completely voluntary;

9. I agree that exclusive jurisdiction and venue for any cause of action arising out of or relating to this release and/or the Property shall be in the Circuit Court of Greene County, Missouri;

10. This release shall be binding upon and shall inure to the benefit of and be enforceable by Owner and Lessee and their respective representatives, owners, members, officers, shareholders, directors, heirs, successors, and assigns and including all of its parent, subsidiary, and related companies; and

11. **THE UNDERSIGNED KNOWINGLY AND INTENTIONALLY WAIVES ANY AND ALL RIGHTS HE/SHE MAY HAVE TO A TRIAL BY JURY WITH RESPECT TO ANY AND ALL CAUSES OF ACTION ARISING OUT OF OR RELATING TO THE PROPERTY, AND/OR THIS RELEASE.**

_____
Initial

If participant is under eighteen (18) years of age:

_____ Date:_____
Signature of Parent/Guardian of Child(ren) under 18 years of age

_____
Print Name

_____
Name of Child(ren) with Age of Child(ren)

If Participant is over eighteen (18) years of age:

_____ Date:_____
Signature of Participant

_____
Print Name

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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.

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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Communication Preferences

Patient Name: _____
(printed)

You may _____ may not _____ contact me for follow-up calls and/or appointment reminders.

You may _____ may not _____ leave messages on my voicemail. The number you may use is:
_____

If I am not home, you may leave the message with the following individual (s): _____
_____
_____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____
(If participant is less than 18 years old, parent/guardian must sign.)

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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