



Welcome to Rocky Top Therapy Center:

We appreciate your interest in our programs at Rocky Top Therapy Center. Our therapeutic riding programs provide comprehensive rehabilitative benefits in the areas of therapy, education, sport and recreation provided by a team approach of licensed/credentialed health professionals and PATH (Professional Association of Therapeutic Horsemanship) International certified riding instructors.

Based on the initial evaluation, the rider will participate in one of the following therapies:

Physical Therapy (Hippotherapy):

Please note that a Hippotherapy session normally consists of therapeutic activities, gait training and/or neuromuscular re-education. Charges for physical therapy treatments are pursuant to current CPT Code Guidelines and are often covered by private insurance or other 3rd party reimbursement. Those clients that have been referred from any agency should indicate this on the Rider's Application.

- Evaluation - \$140/one hour session (payable at the time of service) – Conducted by our Licensed Physical Therapist/Certified Riding Instructor
- Sessions - \$40.00 for every 15 minutes of hippotherapy + \$45.00/month supervisory visit
- Payment is due prior to each session. If payment is not made, your session will need to be re-scheduled.
- Required paperwork
 - ✓ Rider Application/Release Form - Must be signed by parent/guardian if under 18 years of age
 - ✓ Medical Release Form - Must be completed by a physician
 - ✓ Physician's Prescription - Must state for physical therapy with duration & prescription renewal date
 - ✓ Insurance Card - Please provide a copy of front and back of card

Recreational/Developmental Therapeutic Riding:

Private insurance does not pay for these classes. Those clients that have been referred from any agency should indicate this on the Rider's Application.

- Evaluation \$35.00
- Private Class (1 person) \$55.00 /45 minutes
- Semi-Private Class (2 -3 participants) \$50.00 / 45 minutes
- Group Class* (4 or more participants) \$40.00 / 60 minutes

* Please note that group class clients must enroll and pre-pay for a complete Group Session (10-12 weeks). Our sessions are winter, spring, summer and fall. A Seasonal Registration Session form is available upon request.

- Required paperwork
 - ✓ Rider Application/Release Form - Must be signed by parent/guardian if under 18 years of age
 - ✓ Notice of Privacy Practices - Must be signed
 - ✓ Medical Release Form - Must be completed by a physician

All forms for all programs are valid for only one year and a new information packet must be completed annually.

After the completed packet is received, we will make every effort to contact you as soon as possible to make an appointment for your evaluation and orientation. If you have any questions, please contact us at (817) 379-5717.

Rocky Top Therapy Center
660 Keller Smithfield Road • Keller, Texas 76248
Office #: (817) 379-5717 • Fax #: (817) 431-6100
www.rockytoptherapy.org



Notice of Privacy Practices

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect. This notice is an update for the effective regulations of April 24, 2003 and will remain in effect until we replace it.

Use and Disclosures of Health Information:

We use and disclose health information about you for treatment, payment and healthcare operations. This includes but not limited to the following:

- **Treatment:** We may use or disclose your health information to a physician or other health care provider providing treatment to you.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide you.
- **Healthcare Operations:** We may use or disclose your health information in connection with our healthcare operations.
- **Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose.
- **Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up health information or other similar forms of health information.
- **Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

- **Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials your health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
- **Reminders:** We may use or disclose a portion of your health information to provide you with appointment reminders, school excuses, etc. such as voicemail messages, postcards, or letters.

Patient Rights:

- **Access:** You have the right to look at or obtain copies of your health information, with limited exceptions.
- **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____,
 have received a copy of the Rocky Top Therapy Center Notice of Privacy Practices
 regarding _____.
 (Patient Name)

Patient/Guardian Signature: _____ Date: _____

Rocky Top Therapy Center
 660 Keller Smithfield Road • Keller, Texas 76248
 Office #: (817) 379-5717 • Fax #: (817) 431-6100
www.rockytoptherapy.org



Rider Registration and Release Form

Date: _____
 (This form is to be updated annually)

Client		D.O.B.	Age
Street		City	State Zip
Phone #	Cell #	Disability	
Parent/Guardian		Address (if different)	
Home Phone	Work Phone	Emergency	
Additional Emergency Contact/Phone			
E-Mail Address			
Responsible Party			
Primary Insurance Company			
Address		City/State/Zip	Phone
Insured's Name		Relationship to Client	Insured's D.O.B.
Insured's Social Security #		Group Name or #	Effective Date

PAYMENT TERMS :
 Payment Type: Private _____ Insurance _____ Grant _____ Agency Referrals Name _____

I hereby acknowledge that Rocky Top Therapy Center is a non-participating provider with Medicare and all other insurance companies; therefore, I am responsible for the charges that are not covered by my insurance carrier.

_____ (responsible party / if under 18, parent or guardian must sign)
 Signature

LIABILITY RELEASE:
 _____ would like to participate in the Rocky Top Therapy Center program. I acknowledge the risks and potential hazards of horseback riding; however, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risks assumed.

I hereby, intending to be legally bound, for myself, my heirs and assigns, executors or administrators, waive and release forever all claims for damages against Rocky Top Therapy Center, it's Board of Directors, Instructors, Therapists, Aides, Volunteers and/or Employees, the premise owner, Newton's Rocky Top Ranch, Inc., for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in Rocky Top Therapy Center programs.

Date: _____ Signature: _____

PHOTO RELEASE: I hereby consent to and authorize the use and reproduction by Rocky Top Therapy Center of any and all photographs and any other audiovisual materials taken of me/my son/my daughter/my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: _____ Signature: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Rocky Top Therapy to:

- 1. Secure and retain medical treatment and transportation if needed.
- 2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Physician's Name: _____

Preferred Medical Facility: _____

Insurance: _____

Designated Person: _____ Phone: _____

CONSENT PLAN

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person below is unable to be reached.

DATE: _____ CONSENT SIGNATURE: _____
Rider (if over 18), Parent or Guardian

Print Name: _____ Phone: _____

Address: _____

NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

DATE: _____ NON-CONSENT SIGNATURE: _____
Rider (if over 18), Parent, or Guardian

Print Name: _____ Phone: _____

Address: _____

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE), AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES

PLEASE MAIL OR FAX COMPLETED FORM TO:
Rocky Top Therapy Center 660 Keller Smithfield Road, Keller, TX 76248
Phone: (817) 379-5717 or Fax: (817) 431-6100



PHYSICIAN RELEASE FORM

DATE: _____

RIDERS NAME: _____ D.O.B: _____

GENDER: _____ HEIGHT: _____ WEIGHT: _____ TETANUS SHOT: NO YES DATE: _____

NAME OF PARENT/GUARDIAN _____

CONSENT FOR RELEASE OF INFORMATION:

I hereby authorize _____ to release the information from the records
(physician or medical facility)
of _____. This information is to be released to Rocky Top Therapy
(riders name)
Center for the purpose of developing a therapeutic riding program for the above named client.

SIGNATURE: _____ DATE: _____

Dear Physician: Rocky Top Therapy Center offer an equine assisted therapeutic program designed to benefit those with deficits in numerous areas. Safety equipment such as helmets and assistance belts are used and the horses are screened and trained for special needs riders. In order to assure the fullest possible protection and greatest personal benefit from the program, each rider is required to furnish the following medical information before being considered for the program.

Diagnosis: _____ Date of onset: _____

Cause: _____

Medications (type, purpose, dose):

Mobility Status:

Ambulatory: yes no **Independent Ambulation:** yes no **Crutches:** yes no **Braces:** yes no
Wheelchair: yes no **Sitting Balance Impaired:** yes no **Standing Balance Impaired:** yes no

Please indicate any special precautions:

For persons with Down Syndrome:

Negative Cervical X-Ray for Atlantoaxial Instability, X-Ray Date: _____

Negative for Clinical Symptoms of Atlantoaxial Instability

For persons with Seizure disorder:

Seizure Type: _____ Controlled: _____ Date of last seizure: _____

For persons with Scoliosis:

Degree: _____ Type: _____

PRECAUTIONS AND CONTRAINDICATIONS INCLUDE (circle all):

ACUTE MS	BLOOD PRESSURE CONTROL	OSTEOPOROSIS (SEVERE)	SPINAL FUSION
ACUTE HERNIATED DISC	COXA ARTHROSIS (degeneration of hip)	OSTEOGENESIS IMPERFECTA	SPINAL INSTABILITY
ACUTE STAGE OF ARTHRITIS	CRANIAL DEFICITS	PVD	SCOLIOSIS GREATER THAN 30'
ALLERGIES	DANGEROUS TO SELF/OTHERS	RESPIRATORY COMPROMISE	SPONDYLOLISTHESIS
ANIMAL ABUSE	HEMOPHILIA	SEIZURES UNCONTROLLED	SUBLUXATION DISLOCATION OF JOINT
ANTI COAGULANT MEDICATION	KYPHOSIS (EXCESSIVE)	SHUNT (S)	SUBSTANCE ABUSE
ATLANTO-AXIAL INSTABILITY	LORDOSIS (EXCESSIVE)	SKIN BREAKDOWN	SPINA BIFIDA UNSTABLE SPINE

Please indicate if patient has a problem or history of problems and/or surgeries in any of the following areas by checking yes or no. If yes, please comment.

AREAS	YES	NO	COMMENTS
AUDITORY			
VISUAL			
SPEECH			
CARDIAC			
CIRCULATORY			
PULMONARY			
NEUROLOGICAL			
MUSCULAR			
ORTHOPEDIC			
ALLERGIES			
LEARNING DISABILITY			
MENTAL IMPAIRMENT			
PSYCHOLOGICAL IMPAIRMENT			
OTHER			

In my opinion, there is no reason why _____ cannot receive riding therapy under the appropriate supervision.

Precautions:

Physician's Signature _____ Date: _____

Physician's Name: _____
(please print)

Telephone #: _____

Address: _____
City Zip Code

UNDER TEXAS LAW (CHAPTER 87, CIVIL PRACTICE AND REMEDIES CODE) AN EQUINE PROFESSIONAL IS NOT LIABLE FOR AN INJURY TO OR THE DEATH OF A PARTICIPANT IN EQUINE ACTIVITIES RESULTING FROM THE INHERENT RISKS OF EQUINE ACTIVITIES

Rocky Top Therapy Center
660 Keller Smithfield Road • Keller, Texas 76248
Office #: (817) 379-5717 • Fax #: (817) 431-6100
www.rockytoptherapy.org



FINANCIAL ASSISTANCE APPLICATION

DATE RECEIVED: ____/____/____

APPLICANT: LAST FIRST MI AGE SEX

STREET CITY STATE ZIP CODE

HOME PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____

	NAME	SOCIAL SECURITY #	AGE	MARITAL STATUS
APPLICANT				
MOTHER				
FATHER				
OTHER				

MOTHER/FATHER (circle one) ADDRESS & TELEPHONE # IF DIFFERENT THAN CHILD

WHO HAS LEGAL CUSTODY OF APPLICANT? (if applicable) _____

NAME OF NEAREST RELATIVE / FRIEND: _____

CONTACT TELEPHONE # OF FRIEND OR RELATIVE: _____

DO PARENTS SPEAK ENGLISH? _____ IF NOT, WHAT LANGUAGE? _____

SCHOOL CHILD ATTENDS: _____ PHONE #: _____

WHAT SERVICES ARE YOU REQUESTING FOR THIS CLIENT? (circle all that apply)

PHYSICAL THERAPY

THERAPEUTIC RIDING

COUNSELING

WHY DOES THE CLIENT NEED THE SERVICES (describe health or other problems of applicant)?

GIVE INFORMATION ABOUT THE PROFESSIONAL WHO PRESCRIBED THE NEEDED SERVICES

ADDRESS: _____

PHONE #: _____ CONTACT NAME: _____

HOW MUCH OF THE COSTS ARE YOU REQUESTING AS ASSISTANCE FROM ROCKY TOP THERAPY CENTER?

WHO WILL PAY THE DIFFERENCE BETWEEN THE TOTAL COST AND THE AMOUNT YOU ARE REQUESTING FROM ROCKY TOP THERAPY CENTER? _____

HAVE YOU RECEIVED ASSISTANCE FROM ROCKY TOP THERAPY CENTER BEFORE? _____

HOW DID YOU HEAR ABOUT ROCKY TOP THERAPY CENTER? _____

LIST OTHER COMMUNITY AGENCIES OR RESOURCES WHICH WERE CONTACTED FOR HELP BEFORE APPLYING TO ROCKY TOP THERAPY CENTER:

CHURCH _____

COMMUNITY: _____

AGENCY: _____

WHAT WAS THEIR ANSWER? _____

GIVE NAME, ADDRESS AND PHONE NUMBER OF PERSON WE MAY CONTACT AS A REFERENCE ON THIS REQUEST (i.e. MINISTER, DGR, EASTER SEAL WORKER, ETC.)

NAME	ADDRESS	PHONE #
------	---------	---------

NAME	ADDRESS	PHONE #
------	---------	---------

	EMPLOYERS NAME	EMPLOYERS ADDRESS	EMPLOYERS TELEPHONE #	MONTHLY TAKE HOME EARNING
FATHER				
MOTHER				
STEP PARENT (WITH WHOM CHILD IS LIVING)				

OTHER PEOPLE LIVING IN HOUSEHOLD (INCLUDING OTHER CHILDREN)

NAME	KINSHIP TO CHILD	AGE	MARITAL STATUS	INCOME

DOES PARENT / GUARDIAN HAVE OTHER INCOME OR FINANCIAL SUPPORT?

CHILD SUPPORT: _____ AMOUNT: \$ _____
 AFDC: _____ SOC. OR SSI: _____
 HOUSING: _____ AMOUNT: \$ _____
 WIC: _____ FOR WHOM: _____
 FOOD STAMPS: _____

PLEASE COMMENT ON ANY OTHER FINANCIAL OBLIGATIONS:

MONTHLY RENT: _____

CAR PAYMENTS: _____

MEDICAL EXPENSES: _____

OTHER HARDSHIPS:

(medical bills, o/s debt which may hinder your ability to pay for the services yourself)

IS THIS CLIENT COVERED BY ANY INSURANCE POLICY OR PROGRAM (INCLUDING MEDICAID)? _____

POLICY # _____

MEDICAID # _____

WHICH INSURANCE COMPANY? _____

IS THE POLICY THROUGH A GROUP PLAN AT PARENT'S PLACE OF EMPLOYMENT? _____

WHICH PARENT? _____

I ACKNOWLEDGE THAT ROCKY TOP THERAPY CENTER WILL RELY ON THE INFORMATION ON THE APPLICATION IN MAKING ITS DECISION ON THIS REQUEST. I AUTHORIZE ROCKY TOP THERAPY CENTER TO CONSULT WITH, OR RELEASE INFORMATION TO ANY PERSON WHOM THEY DEEM NECESSARY TO VERIFY THIS INFORMATION AND THE REQUEST. I UNDERSTAND IT IS SOMETIMES NECESSARY FOR ROCKY TOP THERAPY CENTER TO DO THIS IN ORDER TO MAKE ITS DECISION ON MY REQUEST.

SIGNATURE: _____ DATE: _____

IF SOMEONE OTHER THAN PERSON SIGNING ABOVE FILLED OUT THIS APPLICATION, PLEASE GIVE US THE FOLOWING INFORMATION:

NAME : _____

ADDRESS: _____

RELATIONSHIP TO APPLICANT: _____

PHONE #: _____ AGENCY / TITLE : _____

NOTE: A copy of your latest income tax form must accompany your application in order to be eligible for our scholarship application process. Once all of the required information is received, an interview will be scheduled to discuss your application.

Rocky Top Therapy Center
660 Keller Smithfield Road • Keller, Texas 76248
Office #: (817) 379-5717 • Fax #: (817) 431-6100
www.rockytoptherapy.org



PHYSICAL THERAPY PRESCRIPTION

Patient Name: _____

Patient Date of Birth: _____

Diagnosis: _____

Date: _____

Goals of Rehabilitation to include:

- _____ Improved Range of Motion
- _____ Improved Gait
- _____ Increased Strength
- _____ Improved Motor Planning
- _____ Improved Posture / Biomechanics
- _____ Improved Functional Ability
- _____ Improved Midline Orientation
- _____ Improved Balance
- _____ Establish / Upgrade Home Exercise Program

Frequency: _____ Duration: _____

Comments/Recommendations:

Physician Signature: _____

Physician Name: _____

Address: _____

Telephone #: _____ Fax #: _____

Rocky Top Therapy Center
660 Keller Smithfield Road • Keller, Texas 76248
Office #: (817) 379-5717 • Fax #: (817) 431-6100
www.rockytoptherapy.org