



Physical Therapy~Occupational Therapy  
Speech Therapy~Music Therapy

**Boulder Mountain Therapy**

Phone: 480-380-2810

Fax: 480-380-2861

[www.bouldermountaintherapy.com](http://www.bouldermountaintherapy.com)

**Dear Parents or Guardians,**

**Thank you for contacting Boulder Mountain Therapy. Our commitment to quality service as therapists includes documentation and following our professional and state mandated guidelines. Please complete the following packet to the best of your ability. In addition, please include a copy of your insurance card(s), front and back, and a copy of your child's prescription if available. Your child will be placed on our waitlist upon returning your completed packet to our facility and a therapist will contact you when therapy services are available.**

- New Patient Registration Form (Front and Back)
- Copy of Insurance card (Copy of Both Sides)
- Prescription for Physical, Speech, or Occupational therapy (Duration & Frequency)
- Liability Release
- Release of Information (Copies of Current IEP &/ or Evaluation)
- Welcome Sheet
- Hippotherapy clients: Medical Release & Physicians Statement Form
- URF (State Contact)

Thank You,  
Boulder Mountain Therapy Staff

**Mailing Address:**

**Boulder Mountain Therapy  
2414 N. Trenton  
Mesa, Arizona 85207**

**East Mesa Clinic:  
844 N. Ellsworth Road  
Mesa, Arizona 85207**

**North Phoenix Clinic:  
2601 E Rose Garden Lane  
Phoenix, Arizona 85050**

**Patient Information:**

**New Patient Registration**

Name \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Age \_\_\_\_\_ Gender F / M Home Phone ( \_\_\_\_\_ ) Work Phone ( \_\_\_\_\_ )

Address \_\_\_\_\_ Email \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Marital Status \_\_\_\_\_

Parent/ Guardian Name \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Referring Physician \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Primary Care Physician \_\_\_\_\_ Phone ( \_\_\_\_\_ )

**Insured Person's Information:**

Insured Name \_\_\_\_\_ Insured SSN \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) Work Phone ( \_\_\_\_\_ ) Employer \_\_\_\_\_

**Primary** Insurance Company Name \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Policy/ Group # \_\_\_\_\_ Case Manager/ Contact \_\_\_\_\_

**Secondary** Insurance Company Name \_\_\_\_\_ Phone ( \_\_\_\_\_ )

Policy/ Group # \_\_\_\_\_ Case Manager/ Contact \_\_\_\_\_

**Support Coordinator** \_\_\_\_\_ Phone ( \_\_\_\_\_ ) Fax ( \_\_\_\_\_ )

**Medical Information:**

Diagnosis \_\_\_\_\_ Date of onset \_\_\_\_\_

Is the injury related to an employment accident? ( Y , N ) MVA \_\_\_\_\_ Other \_\_\_\_\_

Is the injury related to an auto accident? ( Y , N ) If yes, do you have an attorney representing you? ( Y , N )

Is the patient receiving therapy elsewhere? ( Y , N ) If yes, where? \_\_\_\_\_

**Requested service(s):**  **Physical Therapy**  **Occupational Therapy**  **Music Therapy**  **Speech Therapy**  
 **Aquatics**  **Hippotherapy**

**Preference (circle):**

Monday Tuesday Wednesday Thursday Friday  
Am / Pm Am / Pm Am / Pm Am / Pm Am / Pm  
Times: \_\_\_\_\_

Assignment of Benefits: I hereby give my consent for treatment. I authorize my licensed/ certified therapist and/ or billing agent to release any medical or incidental information to process this claim for financial benefits. This assignment will remain in effect until revoked by me in writing. I hereby authorize payments of medical benefits be paid directly to Boulder Mountain Therapy Specialists for services rendered. A photocopy of this assignment shall be considered as effective and valid as the original. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR THESE SERVICES.

Signature of patient, insured, or responsible party \_\_\_\_\_ Date \_\_\_\_\_

**Client's Name** \_\_\_\_\_ **Primary Language in the home** \_\_\_\_\_

Social and/ or Education settings client is in: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date Diagnosed: \_\_\_\_\_

Were there any **complications** during pregnancy/labor or delivery? \_\_\_\_\_

At what ages did the client...

Sit Alone? \_\_\_\_\_ Walk? \_\_\_\_\_

Crawl? \_\_\_\_\_ Speak? \_\_\_\_\_

What are the **goals** you are hoping to achieve here in therapy/ what is your main concern? \_\_\_\_\_

Is the client currently taking any **medications**? If yes, please list \_\_\_\_\_

**Allergies** (Food/Meds/Other)? \_\_\_\_\_

Things that **aggravate** the client (loud noises, textures, sounds, etc.)? \_\_\_\_\_

What are the **positive reinforcements** for the client? \_\_\_\_\_

**Communication:** Verbal Non-verbal Signs

Please check areas where there have been difficulties: (include previous hospitalizations and surgeries)

	Current		Comments	Previous		Comments
	Yes	No		Yes	No	
Hearing						
Visual/ Glasses						
Seizures						
Textures						
Speech/ Language						
Cardiac						
Circulation						
Skin						
Balance						
Learning Disabilities						
Cognitive						
Emotional/ Psychological						
Pain						
Orthopedic						
Aggression						
Self Esteem						
Self Injurious Behavior						
Property Destruction						
Feeding						
Interaction with others						
Other						

**Mobility:**

Assistive Device? If yes, please list: \_\_\_\_\_

Ambulatory? Yes No

Transfers? Independent Requires prompting Limited Asst./ Supervision Significant Asst.

Other:

Child **resides** with: (Name/ Relationship) \_\_\_\_\_

**Custodial** Type: Both Parents Mother Only Father Only Other: \_\_\_\_\_

Who is **authorized** to pick up your child after therapy? \_\_\_\_\_

Name: (Please print) \_\_\_\_\_ Phone Number: (     ) \_\_\_\_\_

**Liability Release**

I understand that horses are unpredictable and even the most docile animal can and may step on, bite, push off balance, stumble, throw, or otherwise injure any person working with or around it. Safety precautions will be exercised by me for my own protection and I agree to abide by the policies and procedures of Boulder Mountain Therapy, as such policies may be amended from time to time. I also agree to exercise proper care and conduct at all times while on or near any horses, including wearing safety helmet and closed toe shoes with heels.

Neither Boulder Mountain Therapy nor any of its officers, instructors, volunteers, participants, employees, agents, or owners of the property where Boulder Mountain Therapy events are conducted shall be held liable for any claims, demands, injuries, or damages, arising out of or in connection with my participation in any Boulder Mountain Therapy event.

I further acknowledge that I will not hold Boulder Mountain Therapy, its officers, instructors, volunteers, participants, employees, agents, or owners of the property, where Boulder Mountain Therapy events are conducted, liable, or responsible for any injury sustained by me while participating in activities at sites where horse therapy classes and related events may be held. I ride and/or participate at my own risk, and agree to take all necessary precautions to prevent all accidents. These precautions include, but are not limited to, the wearing of protective headgear.

I hereby release Boulder Mountain Therapy, its officers, instructors, volunteers, participants, employees, agents, or owners of the property, where lessons, horse shows or other Boulder Mountain Therapy events occur, from all liability for property damage and personal injury to me, I assume the risk of injury which I may sustain arising from approaching, handling, or riding a horse in connection with Boulder Mountain Therapy activities.

This agreement shall apply to any horse or horses being used or maintained upon the grounds where a Boulder Mountain Therapy event is being held, or any person or equipment affiliated with the event.

Furthermore, I assume full responsibility and liability for the conduct and safety of any and all persons I bring onto the property where Boulder Mountain Therapy events are conducted, including minors.

I have read and understand all of the above and waive any claim which may arise against Boulder Mountain Therapy, its officers, instructors, volunteers, employees, agents, or owners of the property where Boulder Mountain Therapy events are conducted.

This agreement is effective upon signing and continues so long as I participate in Boulder Mountain Therapy events.

I agree to pay all costs and attorneys' fees arising from any suit, legal proceedings or threatened proceedings which are or may be brought by me contrary to the terms of this Agreement.

**Signature of Rider or Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Guardian (if under 18):** \_\_\_\_\_

**RISK MANAGEMENT STATEMENTS:**

- I understand that I cannot smoke while on the property of Boulder Mountain Therapy. Y N
- I understand Boulder Mountain Therapy has designated business hours at which time the staff are present or on the property. Y N
- I understand that I must wear an ASTM/SEI approved riding helmet to ride. Y N
- I understand that horses are not to be fed anything by hand. Hand feeding encourages biting. Y N
- I understand that horses are unpredictable and may kick, bite, or step on me. Y N

**SIGNATURE:** \_\_\_\_\_ **(Parent or Guardian if under 18)**

**PHOTO RELEASE:**

I hereby consent to and authorize the use and reproduction by Boulder Mountain Therapy of any and all photographs and any other audiovisual materials taken of me/my child/ my ward, for promotional printed material, educational activities, exhibitions, or for any other use for the benefit of the program.

**SIGNATURE:** \_\_\_\_\_ **(Parent or Guardian if under 18)**



**Boulder Mountain Therapy**

Phone: 480-380-2810

Fax: 480-984-0411

www.bouldermountaintherapy.com

## Participants Consent for Release of Information

I hereby authorize: \_\_\_\_\_  
(person or facility)

To release information from the records of: \_\_\_\_\_ DOB: \_\_\_\_\_  
(participant's name)

The information is to be released to Boulder Mountain Therapy specialists for the purpose of evaluation or ongoing therapy treatment.

The information to be released is marked below:

- Medical History
- Physical Therapy evaluation, assessment and program plan
- Occupational Therapy evaluation, assessment and program plan
- Speech Therapy evaluation, assessment and program plan
- Psychosocial Individual Education Plan (I.E.P.)
- Cognitive- Behavioral management Plan
- Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send response information to:

Boulder Mountain Therapy  
2414 N. Trenton  
Mesa, Arizona 85207

# WELCOME

Please read and complete all of this form as thoroughly as possible. Do not hesitate to ask for assistance if you have any questions.

## HOURS OF OPERATION

Monday through Friday 9:00 a.m. to 6:00 p.m. and Saturdays by appointment only

## PAPER WORK

All forms should be completed and signed prior to the first therapy session.

## SCHEDULING

All patients are seen by appointment only. A physician's prescription needs to be obtained by the patient prior to the first therapy session (this pertains to PT, OT, and Speech therapy only.) We will periodically ask for updated prescriptions, referrals and/or new release forms.

## CANCELLATIONS

There will be a \$25 fee for any missed appointment without a 24-hour notice. This is not covered by insurance. If you are not able to make your scheduled appointment, please call us and we will try to reschedule if possible. However, missing three appointment days without 24-hour notice puts the client in jeopardy of losing their treatment space.

Initials \_\_\_\_\_

## LATE ARRIVALS

In order to maximize your therapy time it is important to arrive on time. Boulder Mountain Therapy reserves the right to discontinue treatment if late arrivals are deemed a problem.

Initials \_\_\_\_\_

## PAYMENT PPROCEDURES

Payment for service and co-pays are due at the time services are rendered. We are happy to file charges with your insurance company. Any charges that your insurance company does not cover within 45 days or any deductible/co-pay is immediate responsibility of the patient/insured party. Service will be discounted for any balance that becomes delinquent. We accept cash and checks.

Initials \_\_\_\_\_

## OBSERVING THERAPIES

We are happy to have families and friends of patients observe treatment sessions as long as it does not distract the patient. Prior approval from the therapist or instructor must be given. In order to keep the integrity of the session, we ask that you do not interrupt or distract the patient during the therapy session.

Initials \_\_\_\_\_

## HORSES

Do not feed any of the horses. Our animals are on special diets and you may interfere with their health. In addition, unsupervised feeding of animals may result in injury.

Initials \_\_\_\_\_

## PETS

We have a high commitment to safety for our patients and horses, therefore, no pets are allowed on the premises. You may pet our animals at your own risk.

Initials \_\_\_\_\_

## PARKING

Please park in the designated areas. Do not block gate access areas. If there is no parking available please ask a staff member for direction.

**I understand the information in this form and agree to following conditions.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



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Dear Physician,

Your Patient, \_\_\_\_\_ is interested in participating in supervised equestrian activities.

In order to safely provide this service our center requests that you complete/ updated the attached Medical History and Physician's Statement Form. Please note that the following conditions may suggest precautions and contradictions to therapeutic horseback riding. Therefore, when completing this form, please note whether these conditions are present and to what degree.

### ***Orthopedic***

Atlantoaxial Instability- include neurological symptoms  
Coxa Arthrosis  
Cranial Deficits  
Heterotopic Ossification/Myositis Ossificans  
Joint subluxation/dislocation  
Osteoporosis  
Pathologic Fractures  
Spinal Fusion/Fixation  
Spinal Instability/Abnormalities

### ***Neurologic***

Hydrocephalus/Shunt  
Seizure  
Spinal Bifida/Chiari II malformation/Tethered Cord/Hydromyelia

### ***Other***

Age- under 4 years old  
Indwelling Catheters  
Medications –I.E. Photosensitivity  
Poor Endurance  
Skin issues

### ***Medical/Psychological***

Allergies  
Animal Abuse  
Physical/Sexual/Emotional abuse  
Blood Pressure Control  
Dangerous to self or others  
Exacerbations of medical condition  
Fire Settings  
Heart Conditions  
Hemophilia  
Medical Instability  
Migraines  
PVD  
Respiratory compromise  
Recent Surgeries  
Substance Abuse  
Thought Control Disorders  
Weight Control Disorder

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

## Medical History and Physician's Statement

**Participant:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **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

**Braces / Assistive Devices:** \_\_\_\_\_

*For those with Down Syndrome:* AtlantoDens      Interval X-rays      Date: \_\_\_\_\_      Result      +      -

**Neurological Symptoms of AtlanoAxial Instability:** \_\_\_\_\_

*Please indicate current or past difficulties in the following systems/areas, including surgeries:*

	Y	N	Comments
<b>Auditory</b>			
<b>Visual</b>			
<b>Tactile Sensation</b>			
<b>Speech</b>			
<b>Cardiac</b>			
<b>Circulatory</b>			
<b>Integumentary / Skin</b>			
<b>Immunity</b>			
<b>Pulmonary</b>			
<b>Neurologic</b>			
<b>Muscular</b>			
<b>Balance</b>			
<b>Orthopedic</b>			
<b>Allergies</b>			
<b>Learning Disability</b>			
<b>Cognitive</b>			
<b>Emotional / Psychological</b>			
<b>Pain</b>			
<b>Other</b>			

**Physician Statement:**

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precaution and contraindications. I concur with a review of this person's abilities / limitations by a licensed /credentialed health professional. (E.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

**Name / Title:** \_\_\_\_\_ **MD, Do, NP, PA other:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** ( \_\_\_\_\_ ) \_\_\_\_\_ **License /UPIN Number** \_\_\_\_\_